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Creating a Vision for the Future: Key Competencies and Strategies for Culturally Competent Practice With Lesbian, Gay, Bisexual, and Transgender (LGBT) Older Adults in the Health and Human Services

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Abstract

Sexual orientation and gender identity are not commonly addressed in health and human service delivery, or in educational degree programs. Based on findings from *Caring and Aging with Pride: The National Health, Aging and Sexuality Study* (CAP), the first national federally-funded research project on LGBT health and aging, this article outlines 10 core competencies and aligns them with specific strategies to improve professional practice and service development to promote the well-being of LGBT older adults and their families. The articulation of key competencies is needed to provide a blueprint for action for addressing the growing needs of LGBT older adults, their families, and their communities.

Keywords

diversity; minority aging; lesbian; gay; bisexual; transgender; LGBT; educational standards; cultural competency training

INTRODUCTION

By 2030, the number of lesbian, gay, bisexual, and transgender (LGBT) older adults in the United States will likely more than double, with 10,000 baby boomers turning 65-years old

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every day and continuing to do so for the next 17 years (Pew Research Center, 2010). LGBT adults are estimated to comprise between 3% and 4% of the general US adult population (Gates & Newport, 2012), and up to 11% when considering both sexual behavior and attraction (Gates, 2011). Yet, as a result of historical, social, and cultural forces, LGBT older adults have largely been invisible in the American landscape (Fredriksen-Goldsen & Muraco, 2010). Aging, combined with a history of marginalization and discrimination, increases the potential vulnerability of LGBT older adults, given heightened risks of discrimination and victimization, and the fear of and potential difficulty in accessing culturally responsive services.

LGBT older adults are an at-risk population, experiencing significant aging and health disparities (Fredriksen-Goldsen, Kim, et al., 2011). The first national and federally-funded research project, *Caring and Aging With Pride: The National Health, Aging and Sexuality Study* (CAP), was designed to better understand the risk and protective factors associated with aging, health, and well-being of LGBT midlife and older adults. In a comparison of key health indicators by sexual orientation, lesbian, gay, and bisexual older adults have higher rates of poor mental health and disability than their older heterosexual peers (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013). The risk of cardiovascular disease and obesity is higher among older lesbians and bisexual women than for older heterosexual women; older gay and bisexual men are more likely than heterosexual men of similar age to have poor general health and to live alone (Fredriksen-Goldsen, Kim, Barkan, et al., 2013). Transgender older adults experience the highest rates of victimization as compared to nontransgender lesbian, gay, and bisexual adults, and have even higher rates of disability, stress, and poor mental and physical health (Fredriksen-Goldsen, Cook-Daniels, et al., 2013).

Despite the adversity experienced by many LGBT older adults, they display remarkable resilience. Many have built vibrant communities and a sensibility that they can count on each other, as exemplified during the height of the AIDS pandemic in the United States (Rofes, 1998). Many LGBT older adults have created close, intimate families of choice, comprised of loved ones, including current and former partners and friends (Heaphy, 2009). Yet, population estimates suggest that one-third to one-half of older gay and bisexual men live alone, without adequate services or supports (Fredriksen-Goldsen, Kim, Barkan, et al., 2013; Wallace, Cochran, Durazo, & Ford, 2011). In the CAP project, 61% of gay and 53% bisexual male participants reported experiencing loneliness (Fredriksen-Goldsen, Kim, et al., 2011).

Many in the LGBT community have been affected by the HIV/AIDS crisis. It is estimated that within 2 years, half of the 1.2 million Americans living with HIV will be 50 years old or older (High, Brennan-Ing, Clifford, Cohen, & Deeks, 2012). Even those who are not HIV-positive themselves have been affected by HIV, experiencing trauma and survivors' guilt through multiple cumulative losses from experiencing the deaths of friends, partners, and other loved ones (Rofes, 1998). This can have serious deleterious consequences for health and aging, which providers need to be aware of and be prepared to address (Wight, LeBlanc, de Vries, & Detels, 2012).

Need for LGBT-Specific Competencies

Social work students and practitioners often lack adequate knowledge and skills for competent practice with LGBT populations (Camilleri & Ryan, 2006; Fredriksen-Goldsen, Woodford, Luke, & Gutierrez, 2011; Logie, Bridge, & Bridge, 2007; Obedin-Maliver et al., 2011; Swank & Raiz, 2010), even though educational accreditation bodies address the need for preparedness for culturally competent practice. For example, the Council on Social Work Education (CSWE) prioritizes multicultural competency as an essential factor in both educational training and practice, with the inclusion of sexual and gender minority groups in definitions of multiculturalism (CSWE, 2008; National Association of Social Workers [NASW], 2008). The Patient Protection and Affordable Care Act mandates cultural competency in healthcare settings (Health Resources and Services Administration, 2012), with multiple initiatives intended to address health disparities and improve cultural competency with special populations, including LGBT and older adult populations.

Over the past several years, considerable efforts have also been made to increase the competence of both students and practitioners working with an aging population. Such competencies have been infused into social work curricula (Lee & Waites, 2006), as “social workers interact with older adults and their families in nearly all practice settings—child welfare, health and mental health, schools, domestic violence, and substance use to name a few—but are typically not formally prepared to do so” (CSWE Gero-Ed Center, 2013, para. 3). Additionally, efforts have been made to improve the competence of geriatric social work practitioners (Geron, Andrews, & Kuhn, 2005).

Knowledge, skills, and attitudes are three central components of culturally competent practice (Van Den Bergh & Crisp, 2004), which is foundational to removing barriers to accessing quality services and ensuring a qualified workforce in the health and human services. The identification of key competencies and content to support culturally competent practice is needed to provide a blueprint for action to address the growing social and health needs of LGBT older adults, their families, and their communities. The articulation and development of key competencies in this article is based on specific research findings with LGBT older adults and extant literature, as well as within the context of core competencies required by the CSWE (2008) Educational Policy and Accreditation Standards (EPAS), and the 2009 Geriatric Social Work Competency Scale II with Life-long Leadership Skills (GSW II). In this article, we outline key competencies and specific strategies to promote culturally competent practice with LGBT older adults and their families, and suggest specific strategies and resources to support these competencies.

METHODOLOGY

Competencies are composed of knowledge, attitudes, and values that are actualized through practice behaviors and assessable, measurable skills. The competencies articulated herein were developed based on a review of existing LGBT health and aging literature, CAP research findings, and an analysis of both CSWE’s (2008) EPAS 10 core competencies, and the 2009 GSW II. The GSW II assesses micro and macro levels of practice via 50 skill-statements, utilizing a 5-point Likert scale (0 = *not skilled at all*, through 4 = *expert skill*).

See CSWE (2010) for a full description of the iterative process used to establish these competencies.

In assessing each of the established sets of competencies, we asked, "What particular skills, knowledge, or attitudes are uniquely necessary for culturally competent practice with LGBT older adults at the required generalist level?" We also provide relevant background for each competency and suggest teaching content and resources to support attainment of students' and practitioners' competency at the generalist level. It is important to recognize that social work students engage in direct practice through foundational and advanced practica, and postdegree social work practitioners are required to engage in ongoing continuing education. Thus, the distinction between social work students and practitioners in regards to culturally competent practice and education is to some degree blurred.

Through the lens of LGBT aging, for this project we assessed the existing literature, the CAP findings, and both sets of competencies (i.e., EPAS, GSW II) for congruency and divergency for social work practice with LGBT older adults. Quotes from LGBT older adults who participated in the CAP study are included to highlight their voices and first-hand knowledge as they pertain to culturally competent practice. This process culminated with the 10 competencies recommended in this article, which are aligned with the the CSWE EPAS and the GSW II, and are summarized in Appendix A. These competencies are tailored to account for the unique circumstances, strengths, and challenges facing LGBT older adults.

1. Critically Analyze Personal and Professional Attitudes Toward Sexual Orientation, Gender Identity, and Age, and Understand How Factors Such as Culture, Religion, Media, and Health and Human Service Systems Influence Attitudes and Ethical Decision-Making

Heterosexism is the dominant culture's valuing of heterosexuality as the only natural, normal expression of human sexuality. When heterosexism is internalized, individuals, groups, and institutions hold and enact associated anti-LGBT stereotypes, beliefs, and attitudes. These may manifest in overt acts of victimization and discrimination, or covertly as attitudes existing below the level of awareness, inadvertently supporting discriminatory behaviors and conditions (Szymanski, Kashubeck-West, & Meyer, 2008).

Societal and internalized heterosexism also underlies ethical dilemmas in working with people with nonheteronormative identities. As a 66-year-old lesbian from the CAP study shared, "isolation, finding friend support, caregiving, and health are the biggest issues older gay persons face. Who will be there for us; who will help care for us without judgment?" Ageist stereotypes, beliefs, and attitudes operate in a manner similar to heterosexism (Cronin & King, 2010). Such biases embedded in personal and cultural beliefs are reinforced through religious doctrine, education, and the media.

Unaddressed biases can manifest in the form of micro-aggressions, "generally characterized as brief, daily assaults on minority individuals, which can be social or environmental, as well as intentional or unintentional" (Balsam, Molina, Beadnell, Simoni, & Walters, 2011, p. 163). Regardless of intent, these everyday experiences of assaults, insults, and invalidations

can have profound and deleterious effects on LGBT older adults' mental and physical health, the helping relationship itself, and whether or not services are accessed and utilized.

The NASW Code of Ethics states that "social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, *sexual orientation, gender identity* or *expression, age*…" (NASW, 2008, p. 1.05(c), italics added). Values related to serving those in need are reflected in the Hippocratic Oath, and in nursing (American Nurses Association, 2001). One of the challenges in applying ethics in social and health services settings that serve marginalized populations is that different cultures and groups often hold conflicting values (Kastrup, 2010). For example, religion has a long history of prescribing traditional gender norms and beliefs about heterosexuality. Such religious prescription has often been used to justify legal sanctioning of sexual and gender minorities (Tuck, 2012).

The NASW professional Code of Ethics mandates that professional values supersede personal values. Yet, some practitioners and students are instructed that if their moral or religious beliefs prevent them from treating sexual minorities with the same dignity and respect as any other client, they "should refer the client to someone who can" (Segal, Gerdes, & Steiner, 2013, p. 18). Such an approach creates unequal application and tensions in the prioritization of professional responsibilities, and is inconsistent with existing ethical standards.

Students and practitioners in the social and health services, regardless of their sexual orientation (Mulé, 2006), gender identity, or age, need to systematically and regularly assess their own attitudes and beliefs, and understand how these impact their ability to effectively deliver competent and unbiased care. Evidence-based self-assessment tools to support attainment of this competency include the Multicultural Counseling Inventory (Green et al., 2005); Age Is More, an online, self-scoring tool to assess ageism (Age Is More, 2013); and the Implicit Association Test, a self-administered, web-based assessment of implicit attitudes toward different cultural groups by characteristics such as sexual orientation, skin color, age, gender, and ability (Project Implicit, 2011).

Two online tools, *Ethics Framework: Overview* (Frolic et al., 2010), and *IDEA: Ethical Decision-Making Framework* (Trillium Health Centre, n.d.) can support achievement of the knowledge and skills to work through ethical dilemmas. Both provide overviews, rationales, detailed guidelines, and worksheets for dealing with ethical dilemmas. The key competency described here aligns with EPAS: Apply critical thinking to inform and communicate professional judgments and engage social work ethical principles to guide professional practice; and with GSW: assess and address values and biases regarding aging.

2. Understand and Articulate the Ways That Larger Social and Cultural Contexts May Have Negatively Impacted LGBT Older Adults as a Historically Disadvantaged Population

In culturally competent practice with LGBT older adults, it is important to understand not only the current contexts of their everyday lives, but also the continuing influence of historical, social, and cultural forces throughout the courses of their lives (Elder, 1994, 1998). Today's LGBT older adults constitute three different cohorts, including the Baby

Boom Generation (b. 1946–1964), the Silent Generation (b. 1925–1945), and the Greatest Generation (b. 1901–1924); each cohort came of age during distinct historical periods. For example, the Silent Generation (those born prior to 1946) came of age during the McCarthy Era, a time when same-sex behavior and identities were severely pathologized and criminalized. The American Psychiatric Association considered homosexuality to be a "sociopathic personality disorder" until its removal from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1973, with some LGBT people involuntarily committed and subjected to brutal treatments, including castration and lobotomy, in attempts to "cure" (Silverstein, 2009). Gender variance is still, even today, stigmatized in the DSM-5 (American Psychiatric Association, 2013), with gender dysphoria identified as a psychological disorder if gender nonconformity results in clinically significant distress. Given the historical circumstances of their lives, many LGBT older adults have spent years concealing their sexual orientation and gender identity from others, including health and human service providers.

Regardless of what point in the life course persons disclose their sexual orientation (e.g., adolescence, older adulthood), first awareness of same-sex sexual attraction often emerges in childhood, adolescence, or occasionally early adulthood, even if it is not acted upon (Floyd & Bakeman, 2006). Awareness of gender identity is evident even earlier, primarily during the preschool years (Halim, Ruble, & Amodio, 2011). That awareness is contextualized by the larger sociohistorical context, and is particularly salient during adolescence and early adulthood, when identity formation and individuation are critical. Hence, the consequences of a sexual or gender minority identity development during the McCarthy era may be quite different from today. For example, baby boomers, the current cohort of midlife adults, came of age during the civil rights and Stonewall gay liberation movements, and the beginning of the AIDS pandemic era, when same-sex behaviors and identities were becoming decriminalized. A gay male baby boomer who participated in the CAP project stated:

> I am trying to get my generation involved in the welfare and well-being of GLBT seniors. I was part of the first post-Stonewall generation that helped create gay communities and identities in the light of day, and feel it is extremely important for my generation to continue to create dialogue and programs for seniors—especially access to healthcare and affordable housing.

As they attend to LGBT people across the life course, health and human service providers must be cognizant of how different historical events, social structures, and cultural factors intersect with developmental trajectories to shape individual life experiences. Additionally, they must identify both the typical and unique normative experiences of LGBT people as they age, as well as distinct transitions over the life course, such as identity management (i.e., coming out or not), and how they influence service use. The growing body of literature on LGBT history and culture supports such knowledge development. Canaday (2009), and Knauer (2011) are two such examples. The documentary film *Gen Silent* is also an excellent resource that highlights the current and historical social and cultural contexts that have impacted older LGBT adults' lives; complimentary educational tools are also available (http://stumaddux.com/GEN_SILENT.html). This competency aligns with EPAS: Apply

knowledge of human behavior and the social environment; and with GSW: Respect and promote older adult clients' right to dignity and self-determination.

3. Distinguish Similarities and Differences Within the Subgroups of LGBT Older Adults, as Well as Their Intersecting Identities (Such as Age, Gender, Race, and Health Status) to Develop Tailored and Responsive Health Strategies

Many LGBT older adults share a common history of discrimination, victimization, and marginalization, yet each of these subgroups (i.e., lesbians, gay men, bisexual, and transgender people) are increasingly being recognized as heterogeneous subgroups (Fredriksen-Goldsen, Kim, et al., 2011). For example, there are often important gender differences in health and service needs that require tailored responses. Despite having higher levels of education than their older heterosexual peers, older LGB adults do not have commensurate incomes (Fredriksen-Goldsen, Kim, Barkan, et al., 2013; Wallace et al., 2011); transgender older adults are at even greater risk of unemployment, underemployment, and poverty (Grant et al., 2011).

Just as LGBT people are silenced and marginalized in mainstream society, transgender and bisexual adults, regardless of age, are often obscured within the lesbian and gay communities, and older LGBT adults are often invisible within LGBT communities (Lyons, Pitts, Grierson, Thorpe, & Power, 2010). Bisexual and transgender older adults may feel a need to conceal their sexual orientation or gender identity in lesbian and gay communities (as well as in the larger society), which not only increases the risk of poor mental health outcomes, but may also preclude these groups from accessing important group and community level resources.

The ability to recognize the intersectional nature of social identities and oppression is a critical competency for health and human services providers. HIV-positive LGBT older adults, for example, experience at least three intersecting marginalized identities: being HIV positive, being older, and being a sexual and/or gender minority (Cahill & Valadéz, 2013). Their social networks may be constricted, compared to younger HIV-positive peers; HIV-positive older adults are significantly more likely to live alone and those of color may be even more socially isolated, impacting morbidity and mortality (Emlet, Fredriksen-Goldsen, & Kim, 2013).

Other LGBT individuals may experience additional obstacles due to other intersecting identities such as sexism, ableism, and socioeconomic bias. As a 76-year-old lesbian shared:

> I have been homeless, staying briefly on the streets, in car & [sic] in shelter … until my daughter began to help me. I am unable to get cataracts operated on as she cannot help me by paying for glasses and unable to get 2 [sic] hearing aides [sic] (medical pays for one).

The intersection of multiple identities along with the confluence of risk factors may mean that these older adults have unique and often unmet service needs.

The emerging literature on the distinct needs of subgroups of LGBT older adults, such as Addis, Davis, Greene, Macbride-Stewart, and Sheperd (2009), can support the attainment of

this competency. Another learning resource is for practitioners to consult with specialists who have expertise in working with specific subgroups. Some states, such as Washington, require that mental health professionals obtain annual consultations with a certified specialist with expertise with certain designated special populations (e.g., LGBT, racial/ethnic minorities) to assure culturally competent services. The American Psychological Association provides a helpful overview of some of the important differences between lesbians, gay men, bisexual, and transgender individuals (DeAngelis, 2002). This competency aligns with EPAS: Engage diversity and difference in practice; and GSW: Respect diversity among older adult clients, families and professionals (e.g., class, race, ethnicity, gender and sexual orientation).

4. Apply Theories of Aging and Social and Health Perspectives and the Most Up-to-Date Knowledge Available to Engage in Culturally Competent Practice With LGBT Older Adults

Issues of aging are generally neglected in sexual and gender minority studies, just as sexual orientation and gender identity are largely absent in gerontological and health studies (Institute of Medicine, 2011). Health and human service providers must have knowledge of human behavior and the major theoretical approaches that facilitate an understanding of aging, sexual orientation, and gender identity. One unique aspect of the social work profession is its attention to the person-in-environment perspective (Segal et al., 2013), which maintains that the client-system (i.e., individual, family, group, community) can only be fully understood in the context of its environment. The life-course perspective posits that it is essential for providers to account for the historical eras in which lives are, and have been, linked and embedded (Elder, 1994, 1998). In addition to attention to intersectionality and the life-course perspective, the Institute of Medicine (2011) has suggested that the minority stress model (Meyer, 1995, 2003), and the social-ecological model (Centers for Disease Control and Prevention, 2009) are useful for understanding the complexities of LGBT lives.

The minority stress model explains the disparately high rates of psychological distress among LGBT populations relative to their heterosexual peers as being the result of stressors unique to sexual and gender minorities (Hendricks & Testa, 2012; Meyer, 1995, 2003). These stressors are in addition to general stressors (e.g., involuntary unemployment, bereavement). Minority stressors include external, objective discriminatory acts and conditions, and internal, subjective stressors, such as internalized heterosexism, concealment of minority identity, and expectations of rejection (Meyer, 2003).

The social-ecological model (Centers for Disease Control and Prevention, 2009) stresses the importance of attending to the dynamic interplay of factors at four levels across the life-span that place people at risk. The individual level attends to biological factors and personal histories, such as age, education, and minority status, that affect people’s lives and outcomes. At the next level, relationships (e.g., partners/spouses, friends, family members) impact lived experiences and behaviors. At the community level, neighborhoods, employment, and other settings influence the dynamics of relationships. Finally, at the societal level are cultural and social standards, and social, health, and other policies that foster inequities and cultivate climates, which can either delimit or support human agency.

An example of how these perspectives and theories could inform culturally competent practice with LGBT older adults is the selection of group work as a possible intervention. Although group work is often a useful intervention modality for older persons, LGBT older adults may not feel safe in groups that are composed primarily of heterosexual elders, which might harbor a climate hostile to sexual and gender minorities. A 71-year-old gay male CAP participant stated:

> Gay people do not choose to be gay. Could we try to make that common knowledge? Because all the bigotry (at least among adults) rests on the notion that we gays made the horrible choice to be attracted to people of the same sex or were somehow "recruited to the gay lifestyle." I believe we could try harder to dispel this myth.

Community-based organizations, such as the LGBT Aging Project of Boston (http://www.lgbtagingproject.org), National Resource Center on LGBT Aging (http://www.lgbtagingcenter.org/index.cfm), and Training to Serve in Minnesota (http://www.trainingtoserve.org) have successfully developed cultural competency trainings specific to LGBT aging. Such existing training models can be replicated or expanded to prepare health and human service providers to implement LGBT competent interventions. This competency aligns with EPAS: Apply knowledge of human behavior and the social environment; and with GSW: Relate social work perspectives and related theories to social work practice (e.g., cohorts, normal aging, and life course perspective).

5. When Conducting a Comprehensive Biopsychosocial Assessment, Attend to the Ways That the Larger Social Context and Structural and Environmental Risks and Resources May Impact LGBT Older Adults

Discrimination and victimization are chronic stressors that contribute to psychological distress. Lifetime experiences of discrimination and internalized heterosexism are significantly associated with poor mental health, physical health, and disability among older LGB (Fredriksen-Goldsen, Emlet, et al., 2013) and transgender adults (Fredriksen-Goldsen, Cook-Daniels, et al., 2013). More than 80% of CAP participants have been victimized at least once in their lives because of their sexual orientation or gender identity; over 60% have been three or more times (Fredriksen-Goldsen, Kim, et al., 2011). It is striking that a recent community-needs assessment of LGBT older adults living in San Francisco, known as a gay-friendly city, found that nearly half had been discriminated against during the past year because of their sexual orientation or gender identity (Fredriksen-Goldsen, Kim, Hoy-Ellis, et al., 2013).

Alienation can also emanate from within one's community. Bisexuality is often viewed as a nonlegitimate sexual orientation in lesbian and gay communities (Ochs, 1996; Weiss, 2003), and gender identity may be considered as alien among some LGB people (Lombardi, 2009). LGBT people of color experience racism within LGBT communities (Balsam et al., 2011; Stirratt, Meyer, Ouellette, & Gara, 2008). And, LGBT older adults are generally invisible in LGBT communities (Lyons et al., 2010), which often value and equate youth with beauty—just as the larger society does (Goltz, 2009; Jones & Pugh, 2005). As one older, HIV-positive man stated, "Yeah, ageism; it's a far mightier sword than HIV" (Emlet, 2006, p.

785). As part of a biopsychosocial assessment, an essential skill is to identify resources such as whether the person is connected to their respective LGBT community.

It is also critical that health and human services providers recognize the various structures of LGBT families, as well as the importance of families of choice in providing instrumental, emotional, and social support (Muraco & Fredriksen-Goldsen, 2011). Like the general population, LGBT individuals belong to an array of family structures: They may have a partner or spouse who may or may not be legally recognized across differing jurisdictions; they may have parents, siblings, and children; they may have a family of choice that provides needed support; or they may not have any family at all. LGBT families of choice are unique in that they often include former partners who remain friends, as well as other friends (Barker, Herdt, & de Vries, 2006). A 67-year-old lesbian CAP participant shared:

> My partner has two major diagnoses and I am the driver to the doctors. My sister and her husband and daughter are friendly but not caring, and not happy with me being gay, and will not allow us to stay there overnight. I have no real help should she get ill.

LGBT families-of-choice that are not related by blood or law are often unrecognized by providers, even though they provide consistent care, support, refuge, and nurturance to their members (Chapman et al., 2012). Although one in four LGBT older adults do have children (Fredriksen-Goldsen, Kim, et al., 2011) they are less likely to have children than their heterosexual peers (Fredriksen-Goldsen, Kim, Barkan, et al., 2013).

Among older adults in general, women provide the vast majority of informal care, primarily to legally or biologically related family members (Family Caregiver Alliance, 2003). However, in LGBT communities, men provide nearly as much care as women, with partners and friends primarily caring for one another (Fredriksen-Goldsen, Kim, et al., 2011). Although this social support provides essential resources, it also has its own set of challenges. As older LGBT adult peers reach older old ages, they may experience a diminished capacity to care for one another (Muraco & Fredriksen-Goldsen, 2011).

To effectively link clients to resources, providers should compile lists of both local and national resources relevant to the varying needs of LGBT older adults, their families, caregivers, and other supports. A good starting place is the National Resource Center on LGBT Aging (http://www.lgbtagingcenter.org/index.cfm), and Services and Advocacy for GLBT Elders (SAGE; http://www.sageusa.org/about/index.cfm). When providing such resources and referrals to LGBT older adults, it is important not to assume that what is salient to one group (e.g., lesbians) is salient to another (e.g., transgender). This competency aligns with EPAS: Engage, assess, intervene, and evaluate with individuals, families, groups, organizations and communities; and with GSW: Assess social functioning and social support of older clients.

6. When Using Empathy and Sensitive Interviewing Skills During Assessment and Intervention, Ensure the Use of Language Is Appropriate for Working With LGBT Older Adults to Establish and Build Rapport

Research indicates that individuals who hold negative attitudes, beliefs, and stereotypes regarding minority groups are likely to consciously or unconsciously convey those biases in their behavior (Shelton & Delgado-Romero, 2011), including their language. Those who work with LGBT older adults need to understand, and be comfortable with, the array of terms used to represent differing sexualities and gender identities. Sexual orientation and gender identity are distinct constructs, even though they are inextricably intertwined. *Sex* and *gender* are often used interchangeably, although the former relates to biology, and the latter refers to social constructions based on biology. Transgender identity refers an individual's innermost sense of self as female, male, or other sense of self that is incongruent with biological sex. Sexual orientation (i.e., lesbian, gay, bisexual, heterosexual) refers to an:

> enduring pattern of emotional, romantic, and/or sexual attractions to women, men, or both sexes and also refers to a person's sense of identity based on those attractions, related behaviors, and membership in a community of others who share those attractions. (American Psychological Association, 2010, p. 74)

It is also important to remain cognizant of ascribed versus claimed identities. For example, researchers may ascribe a sexual minority identity to study participants (i.e., lesbian, gay, bisexual) based on same-sex attraction or behavior, but the participants themselves might not claim that identity; instead, they may identify differently (i.e., heterosexual).

LGBT older adults are often characterized as a homogenous group and even though the umbrella term *LGBT* is most often used, it can be exclusionary. Other terms are also used, such as *queer*, *questioning*, *intersex*, and *two-spirit*. There are also critical differences by age in the terminology used. Although *H* for *homosexuality* is typically not used in the LGBT acronym, it may be the preferred term used by some older gay men; some lesbians prefer to identify as gay. Likewise, although many LGBT people have embraced the term *queer* to regain and reclaim power, it still has enormously negative connotations for many older LGBT adults. It is also important to be cognizant of related terms. For example, *coming out* refers to disclosing one's sexual orientation or gender identity, and *closeting* means to conceal said orientation or identity or to pass as heterosexual or nontransgender. Equally important is the ability of health and human service providers to be aware of the language used by LGBT older adults, themselves, as those are the terms that most likely represent their lives and identities. A 58-year-old transgender bisexual woman who participated in the CAP project remarked:

> Long-term health care for trans people is a big, dark unknown. How long do we take hormones? How do trans people who don't "pass" get decent treatment and respect? And "passing" is all but impossible in some medical contexts. Where do trans people who do *not* identify as LBG fit into the picture?"

To support attainment of this competency and the use of culturally competent and appropriate language, the sixth edition of the *Publication Manual of the American*

Psychological Association provides excellent guidelines for using language to reduce bias (American Psychological Association, 2010). As good rules of thumb, these guidelines highlight the importance of vocabulary in conveying respect while avoiding language that marginalizes (for example, avoid using *sexual preference*, as it implies choice).

Additionally, students and practitioners need to hone active listening skills, because many LGBT older adults welcome the opportunity to communicate their preferred terms and vocabulary. If disclosure as LGBT to a service provider is met with a neutral response, that response may well be interpreted as hostile (Harding, Epiphaniou, & Chidgey-Clark, 2012). Usage of appropriate language is a powerful way to convey empathy, understanding, and respect, as well as to facilitate the establishment of rapport. This competency aligns with EPAS: Assess with individuals, families, groups, organizations and communities; and with GSW: Use empathy and sensitive interviewing skills to engage older clients in identifying their strengths and problems.

7. Understand and Articulate the Ways in Which Agency, Program, and Service Policies Do or Do Not Marginalize and Discriminate Against LGBT Older Adults

In addition to discrimination in the larger society, LGBT older adults experience both overt and covert discrimination in health and human service settings. Discrimination within healthcare systems is a significant predictor of poor mental and physical health (Fredriksen-Goldsen & Muraco, 2010). Thirteen percent of CAP participants have been denied healthcare or received inferior care because of their sexual orientation or gender identity. Invisibility of LGBT older adults is pervasive across healthcare settings, and is a subtle form of discrimination (Brotman, Ryan, & Cormier, 2003).

Many providers are unaware that LGBT older adults are utilizing their services (Hughes, Harold, & Boyer, 2011). This can be especially damaging for LGBT older adults in long-term care facilities, where many may opt to go back into the closet due to fear and lack of support (National Senior Citizens Law Center, 2011). This invisibility leads to exclusion and marginalization, exacerbating feelings of loneliness and social isolation (LGBT Movement Advancement Project & SAGE, 2010). Unfortunately, such situations support nondisclosure of a stigmatized identity, which is a risk factor for poor health outcomes (Durso & Meyer, 2013).

Many health and human services adopt a *sexuality-blind* norm through avoiding the topic of sexuality and treating patients as asexual, especially older adults (Cronin, Ward, Pugh, King, & Price, 2011). As few as one in five healthcare providers routinely take a sexual history as part of new client intakes (Gay and Lesbian Medical Association, 2002). Thus, the importance of careful and in-depth examination of discriminatory and exclusionary behaviors among health care and human service professionals cannot be overemphasized. Although some healthcare organizations are committed to providing LGBT-centered patient care, only half of such organizations in one study expressed interest in including patients' sexual orientation or gender identity in their medical records (Snowden, 2013). As many as one in five LGBT older adults are concealing their sexual orientation or gender identity from their primary care physician (Fredriksen-Goldsen, Kim, et al., 2011). The American Medical Association (2009) has acknowledged that lack of attention to patients' sexual orientation

can profoundly and negatively impact the delivery and quality of medical care. A 59-year-old transgender woman who participated in CAP commented, “The health care facility needs to revamp their policies on treatment of LGBT people. My partner and I are both [female] transsexuals but are treated as men when it comes to the services.” It is imperative that health and human service organizations have explicit nondiscrimination policies in place, banning discrimination by sexual orientation and gender identity within the organization, as well as with agencies that provide contracted services.

To support the attainment of this competency, students and practitioners should begin with a review of all agency policies to determine if sexual orientation, sexual behavior, and gender identity are explicitly addressed. All assessment tools and standardized forms should be reviewed to ensure they are LGBT-inclusive. For example, clients should not have to select between inaccurate or inappropriate choices, such as between married or single. In addition, collection of patient-level data that includes sexual orientation and gender identity information can contribute to our understanding of LGBT older adults’ health, social, and aging needs (Institute of Medicine, 2011).

A useful tool for assessing agency policies regarding LGBT clients is the Human Rights Campaign’s Healthcare Equality Index (HEI; http://www.hrc.org/hei#.Um1UOoPn9LM). In addition to this annual online survey, available to healthcare organizations seeking to provide equitable, inclusive care to the LGBT community, it is also available to LGBT people looking for healthcare providers who have shown that they are proactive in providing culturally competent care (Snowden, 2013). In addition to being evaluated in four core areas with more than 30 best practices in LGBT culturally competent care, healthcare organizations that participate in the HEI are able to receive expert trainings for staff at no charge (http://www.hrc.org/hei/#.Uff51czn-po). This competency aligns with EPAS: Assess with individuals, families, groups, organizations and communities; and with GSW: Conduct a comprehensive geriatric assessment (bio-psychosocial evaluation).

8. Understand and Articulate the Ways That Local, State, and Federal Laws Negatively and Positively Impact LGBT Older Adults, to Advocate on Their Behalf

With the increasing acceptance of sexual and gender minorities in the United States, health and human service providers may assume that such discrimination is a thing of the past. However, discrimination based on sexual orientation is still legal in 29 states, and discrimination based on gender identity is legal in 33 states (Human Rights Campaign, 2013a). This is despite evidence that LGBT people that live in states that have passed antidiscrimination legislation and other legal protections experience significant decreases in psychological distress (i.e., mood, anxiety disorders), yet the opposite is true for those living in states that have passed anti-LGBT legislation (Hatzenbuehler, Keyes, & Hasin, 2009; Riggle, Rostosky, & Horne, 2010; Rostosky, Riggle, Horne, & Miller, 2009). Because LGBT older adults rely primarily on each other for social, emotional, and instrumental support, laws and policies that do not recognize the relationships of families of choice may also marginalize LGBT older adults economically.

There is a popular myth that LGBT individuals are affluent. Although some certainly are, research indicates that, despite significantly higher levels of education, LGBT people often

earn less than heterosexuals. Because lifetime earnings have a significant impact on retirement age, LGBT older adults are at a distinct disadvantage economically (Grant, 2010). Older lesbian and bisexual women and transgender older adults are at particular risk for living in poverty (Fredriksen-Goldsen, Cook-Daniels, et al., 2013; Wallace et al., 2011).

Advocacy for justice (Killian, 2010) and the passing of laws in favor of equality is undeniably important to support the health and well-being of LGBT older adults. A 56-year-old lesbian CAP participant impacted by the lack of legal protections stated, “I worry a lot about my future, as I really age—not so much now. And if anything happens to my partner, I’ll be in big trouble; my medical insurance and household income come through her.” Because policies related to aging generally assume heterosexuality, they have historically discriminated against LGBT older adults and their partners and families. For example, Social Security provides significant economic benefits to older Americans, including spousal and survivors’ benefits, that until recently were not available to same-sex couples. In *Windsor v. United States*, the Supreme Court struck down Section 3 of the Defense of Marriage Act as unconstitutional. Although the ruling extends federal recognition to legal same-sex marriages and provides access to Social Security spousal and survivors’ benefits to LGBT older adults in legal marriages, it also left Section 2 intact, which recognizes states’ right to refuse to recognize same-sex marriages performed in states where they are legal (Human Rights Campaign, 2013b). Although a growing number of states recognize same-sex marriage, LGBT older adults who live in states without legal same-sex marriage will not be able to access federal benefits unless they are able to travel to and be married in a state that sanctions same-sex marriages.

Health and human services providers who are culturally competent in LGBT issues are uniquely positioned to advocate for policies and laws that foster the dignity and worth of LGBT older adults, and the importance of their relationships. Organizations such as the Human Rights Campaign (http://www.hrc.org/) and Lambda Legal (http://www.lambdalegal.org/) offer comprehensive and up-to-date information on laws, policies, and initiatives that impact the LGBT community. The Diverse Elders Coalition (http://www.diverseelders.org/) provides similar information specific to older adults who are racial, ethnic, sexual, or gender minorities. These resources can help health and human services providers understand the impact of laws and policies in LGBT older adults’ lives, as well as assist LGBT older adults and their families. This competency aligns with EPAS: Engage, assess intervene, and evaluate with individuals, families, groups, organizations, and communities; and with GSW: Assess social functioning and social support of older clients.

9. Provide Sensitive and Appropriate Outreach to LGBT Older Adults, Their Families, Caregivers and Other Supports to Identify and Address Service Gaps, Fragmentation, and Barriers That Impact LGBT Older Adults

Past experiences of discrimination may make vulnerable older adults less likely to seek services from the very agencies that have historically marginalized them. In addition, some agencies may resist outreach efforts to not offend private donors (Knochel, Quam, & Croghan, 2010). Many LGBT older adults feel unwelcome in aging programs and services (LGBT Movement Advancement Project & SAGE, 2010), and feel they must conceal their

sexual orientation (National Senior Citizens Law Center, 2011). Concealment of one's LGBT identity or orientation is associated with intensified psychological distress (Meyer, 2003), which, in turn, increases the risk of premature illness and death (Russ et al., 2012). A 63-year-old lesbian CAP participant shared:

> I work with a number of LGBT clients in nursing home environments and find them to be extremely isolated and actually have become "recloseted" due to community living with elderly heterosexual populations. Lack of transportation and outreach prohibit them from access to the LGBT community.

Even when agency staffs are open and affirming, other clientele (i.e., older heterosexual adults) may display anti-LGBT attitudes and behaviors. Cultural competency trainings should prepare staff and residents with strategies to respond effectively to such incidents.

Lack of adequate training may be an unacknowledged barrier that can impact the provision of appropriate services to LGBT older adults. Professional programs in various disciplines devote limited time and content to LGBT health, including medicine (Obedin-Maliver et al., 2011), nursing (Eliason, Dibble, & Dejoseph, 2010), and social work (Logie et al., 2007). Three out of four social service directors in skilled nursing facilities report receiving no training in LGBT cultural competency in the preceding 5 years (Bell, Bern-Klug, Kramer, & Saunders, 2010). Only one in four healthcare organizations participating in the recent Health Equality Index survey indicated that they had reviewed their clinical services to identify gaps in the provision of services to LGBT patients, although another 54% indicated that they were interested in doing so (Snowden, 2013).

Recruiting LGBT older adults to serve on community advisory boards and other volunteer venues in LGBT and mainstream agencies will help to ensure that their voices are a central part of the mission and delivery of services; this can also provide expert insider perspectives regarding fragmentation of and gaps in existing programs and services, as well as how existing programs and services may be discriminatory. Such recruitment is likely to be challenging, especially in light of current and historic discrimination. An initial, yet critical, first step in this process is to communicate to LGBT older adults that the agency or program seeking their input is LGBT-affirming.

A resource for agencies and programs to communicate to LGBT older adults that they are LGBT affirming is the Safe Zone Project. Originally developed and implemented in university settings, the Safe Zone Project is "an adjunctive training module—one that signifies the acceptance and affirmation of LGBT individuals, and a commitment to training, recruitment, and retention of LGBT and LGBT-sensitive [staff]" (Finkel, Storaasli, Bandele, & Schaefer, 2003, p. 555), is becoming increasingly common in business and health and human service settings. Some Safe Zone training materials can be accessed online.[1] Posting Safe Zone signs and having other visible cues (e.g., LGBT magazines, posters) signal that the agency, service, or program is LGBT sensitive and affirming. In addition, LGBT services and programs should also provide visual cues that they are affirming of older LGBT adults, and whenever possible, develop programming specific to their particular issues. This

[1]See for example: http://www2.webster.edu/shared/shared_selfstudyreport/documents/hlc1b1_safezone.pdf

competency aligns with EPAS: Respond to contexts that shape practice; and with GSW: Identify and develop strategies to address service gaps, fragmentation, discrimination and barriers that impact older persons.

10. Enhance the Capacity of LGBT Older Adults and Their Families, Caregivers, and Other Supports to Navigate Aging, Social, and Health Services

As older adults age, they are likely to experience an increased need for social and health services. The provision of human services in the United States has been historically bound with the profession of social work. Because of its complex and fragmented nature, navigating the system of social and health services can be daunting and frustrating at times.

Health and human service professionals can play a crucial role in helping LGBT older adults navigate the fragmented health and human services system, while advocating for the best possible solutions to the distinct challenges they face. As daunting as this system is, it is even more so for LGBT older adults because of discriminatory laws and policies, as well as agencies and programs failure to recognize and address the distinct needs of LGBT older adults. In addition, LGBT older adults may not have biologically or legally related family members to assist in navigating such systems, which older heterosexual adults often do (Brotman et al., 2003). Even when LGBT older adults do have friends or family-of-choice members to assist them, such assistance can be challenging not only because they, themselves, may also have aging- and health-related needs, but also because of confidentiality, legal decision-making authority, and other related issues (Muraco & Fredriksen-Goldsen, 2011).

It is also important to recognize that LGBT older adults have unique strengths that can be harnessed to empower them in navigating the complex array of social and health services. Some LGBT older adults continue to be socially and politically active, fighting for civil rights and social justice issues, which may enhance their resilience as they age (Ramirez-Valles, Kuhns, Campbell, & Diaz, 2010). Several studies have found that LGBT older adults are strengthened through “crisis competence,” applying lessons learned from being a sexual minority to the aging process (Friend, 1991, p. 110). The biopsychosocial model for late life resilience (Smith & Hayslip, 2012) suggests that older adults can engage individual, interpersonal, and environmental resources to combat elements of risk and adversity. Professionals in the field need the knowledge, skills, and values to identify intrapersonal and interpersonal resources with older LGBT consumers, and to assist them in addressing their needs, those of their families, and other support systems. A 77-year-old gay male CAP participant affirmed:

> It makes sense to focus a lot of attention and work on educating mainstream senior service agencies and institutions to provide LGBT-sensitive and gay-friendly services. I know that there have been many advances already made in that direction, and I hope it continues. Educating mainstream services is also part of the larger movement toward integrating LGBT people of all ages and LGBT culture into the larger society.

In addition to educating LGBT older adults about available services and supports, asking for their expert knowledge can empower them to become advocates for themselves and others.

The National Center on LGBT Aging also provides trainings free of charge that can help agencies and programs to be better able to enhance the capacity of LGBT older adults and their families, caregivers, and other supports to navigate aging, social, and health services. Two of these trainings are for general aging services providers; two others are for LGBT organizations (http://www.lgbtagingcenter.org/about/training.cfm). This competency aligns with EPAS: Engage in policy practice to advance social and economic well-being and to deliver effective social work services; and with GSW: Advocate on behalf of clients with agencies and other professionals to help elders obtain quality services.

DISCUSSION

Students and practitioners in the social and health services have generally not been well prepared to practice in a culturally competent manner with LGBT populations (Camilleri & Ryan, 2006; Fredriksen-Goldsen, Woodford, et al., 2011; Logie et al., 2007; Obedin-Maliver et al., 2011; Swank & Raiz, 2010). It should not be incumbent upon LGBT older adults to educate providers, services, and programs about their unique challenges and needs; this responsibility lies squarely on the shoulders of providers, educations, and other stakeholders. The competencies outlined herein can serve both educational and evaluative purposes; implementing them into practice, policy, and research will improve the effectiveness of each as they relate to LGBT older adults. Health and human service providers who are culturally competent in LGBT issues are uniquely positioned to advocate for practice modalities and policies that foster the dignity and worth of LGBT older adults, and the importance of their relationships and families.

It is time to more fully envelop the notion of inclusion, that is “including” LGBT older adults, through the notion of “nothing about us without us” (Charlton, 2000). This perspective highlights the importance of meaningfully engaging of community members in the process of practice, program, and policy development. Furthermore, the identification of successful programs and policies at the local, state, and federal levels that address the health and aging needs of LGBT older adults can be used as models and adapted for use in diverse urban, suburban, and rural communities.

The recommended competencies outlined here cover a wide range of issues and challenges in developing culturally relevant and sensitive practice modalities, yet they are by no means exhaustive. Future work will undoubtedly point to the need for additional competencies and require the refinement of what has been presented here. In the CAP study, participants were contacted though mailing lists maintained by agencies so the results are not generalizable or necessarily representative of LGBT older adults, and those who remain most hard to reach are likely underrepresented. The agencies are primarily located in major metropolitan areas so the needs and concerns of LGBT older adults living in rural areas need further investigation.

Although practitioners and educators have ethical mandates to be knowledgeable and competent in working with diverse populations, content relevant to the lives of LGBT older adults is largely absent in training and educational programs. Implementing standardized and comprehensive competencies will enhance the ability of social and health service

providers to address both the needs and challenges facing LGBT older adults and their families, and, at the same time, acknowledge and support the resilience and many resources that exist within these communities. A 63-year-old CAP participant shared, “The LGBT community has stepped up in the past to address coming out, AIDS, and civil rights. The next wave has to be aging.”

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APPENDIX: COMPETENCY SCALE FOR WORKING WITH LGBT OLDER ADULTS

Please use the scale below to thoughtfully rate your current skill level:

0 = Not skilled at all (I have no experience with this skill)

1 = Beginning skill (I have to consciously work at this skill)

2 = Moderate skill (This skill is becoming more integrated into my practice)

3 = Advanced skill (This skill is done with confidence and is an integral part of my practice)

4 = Expert skill (I complete this skill with sufficient mastery to teach others)

	Competency Scale for Working With LGBT Older Adults	Skill Level (0–4)
1	Critically analyze personal and professional attitudes toward sexual orientation, gender identity, and age, and understand how factors such as culture, religion, media, and health and human service systems influence attitudes and ethical decision-making.	
2	Understand and articulate the ways that larger social and cultural contexts may have negatively impacted LGBT older adults as a historically disadvantaged population.	
3	Distinguish similarities and differences within the subgroups of LGBT older adults, as well as their intersecting identities (such as age, gender, race, and health status) to develop tailored and responsive health strategies.	
4	Apply theories of aging and social and health perspectives and the most up-to-date knowledge available to engage in culturally competent practice with LGBT older adults.	
5	When conducting a comprehensive biopsychosocial assessment, attend to the ways that the larger social context and structural and environmental risks and resources may impact LGBT older adults.	
6	When using empathy and sensitive interviewing skills during assessment and intervention, ensure the use of language is appropriate for working with LGBT older adults in order to establish and build rapport.	
7	Understand and articulate the ways in which agency, program, and service policies do or do not marginalize and discriminate against LGBT older adults.	
8	Understand and articulate the ways that local, state, and federal laws negatively and positively impact LGBT older adults, in order to advocate on their behalf.	
9	Provide sensitive and appropriate outreach to LGBT older adults, their families, caregivers and other supports to identify and address service gaps, fragmentation, and barriers that impact LGBT older adults.	
10	Enhance the capacity of LGBT older adults and their families, caregivers and other supports to navigate aging, social, and health services.	