Person-Centered Care for LGBT Older Adults

A nurse, in her open, kind, nonjudgmental way, asks each patient the same intake question: "Do you have a husband, wife, boyfriend, girlfriend, partner, significant other?" She communicates to everyone she meets that she does not assume they are heterosexual. After asking this question to an 82-year-old man, he looked at her stunned and appreciative. He told her, "No one has ever asked me that before. I am gay."

The simple answer to the nurse's question in the encounter above was "no." The man did not currently have a partner. What transpired, however, was so much more. Healing took place. The man felt seen, validated, and accepted. Each encounter we have with another person is an opportunity to promote healing and well-being, but also an opportunity to cause harm. Without realizing it, many of us in the caring professions have and continue to inadvertently wound individuals we are supposed to be caring for, especially those who are lesbian, gay, bisexual, or transgender (LGBT; used herein as an umbrella term to refer to non-heterosexual and/or non-cisgender individuals [i.e., sexual and gender minorities]).

LGBT older adults have been an underserved population with health disparities across health care, and in long-term care, they have been almost entirely invisible to providers (American Geriatrics Society Ethics Committee, 2015; Choi & Meyer, 2016; Institute of Medicine, 2011; Jacobson, 2017; National Institute on Minority Health and Health Disparities, 2016; Office of Disease Prevention and Health Promotion, n.d.). Invisibility can lead to negative health outcomes. For instance, when health care providers do not know what sex someone was assigned at birth in addition to his/her gender identity, they may fail to order necessary tests and screenings. Part of our work as health care professionals in providing person-centered care (PCC) to LGBT older adults is to make the invisible visible, as does the nurse described in the above vignette. During intake, she conveys that she is aware of and affirms the diversity of sexual orientation. She does the same with gender identity and expression. By doing this, she helps normalize what for so long has been taboo and stigmatized: being an LGBT older adult.

Many LGBT older adults have historically avoided and delayed receiving health care out of fear of being mistreated, disrespected, and even harmed by health care providers. Tragically, these fears are rooted in real life experiences. During a pastoral visit, a person shared with me:

> When I was a young teenager I got very depressed. My parents took me to a psychiatrist. The doctor asked me some questions and I answered honestly. When he asked if I wanted to be a man, I thought to myself, finally some-

one understands! I answered truthfully with relief, "Yes, I want to be a man. I don't want to be a woman." I was diagnosed with schizophrenia, institutionalized, medicated. Look at me—I'm 91 and trying to come to terms with what happened to me.

As LGBT older adults age and require long-term care, fears and anxiety of being outed, disrespected, mistreated, and harmed are compounded by their vulnerability in requiring assistance for daily needs. LGBT older adults who move into skilled nursing homes often choose to stay in the closet. This loss of a safe space, a true home, where one can fully be oneself is detrimental to quality of life and overall well-being.

We are never too old to experience healing—physical, spiritual, emotional, or psychosocial.

We are never too old or sick to experience healing—physical, spiritual, emotional, or psychosocial. At the heart of PCC is the understanding that we care for the whole person and not merely an ailment. PCC emphasizes a person's humanity by recognizing that each individual is multidimensional, and health and well-being derive from the interconnectedness of these different dimensions over our lifetime. Sexuality is complex and core to being human. Although sexual orientation and gender identity are central to individual identity and life experiences, health care providers have very little knowledge and training in caring for LGBT individuals, which leads to less than optimal PCC (Brennan, Barnsteiner, Siantz, Cotter, & Everett, 2012; Cannon, Shukla, & Vanderbilt, 2017; Carabez et al., 2015; Krisberg, 2016; Obedin-Maliver et al., 2011).

Where and how do we begin this work of becoming competent and inclusive providers of PCC to LGBT older adults? A good place to begin is to recognize that there are LGBT older adults, including individuals in their 80s, 90s, and older. When we do not allow for or acknowledge the possibility that someone in our care might be LGBT, we enforce and perpetuate the bias against LGBT individuals and their invisibility. For instance, when we only ask a woman if she has a husband, or a man if he has a wife, and only provide two options for gender, male or female, we are re-inflicting harm and, for older adults, years of being invisible to health care providers (National Resource Center on LGBT Aging, & Services and Advocacy for GLBT Elders, 2013).

Nurses are committed to caring for the whole person, providing care with compassion, and honoring the inherent dignity and worth of the individuals they care for (American Nurses Association, 2015). All of us, though, are shaped and influenced by multiple entities—cultural, religious, political, familial, and historical. These entities affect how we make sense of differences including sexual orientation and gender identities.

We are not often aware of the biases we carry and how they influence our interactions with others. Because we communicate in multiple ways, not just verbally, we can unintentionally send mixed messages. For instance, we may say one thing, but our body language, tone of voice, or facial expression may convey an entirely different message, such as, "I am not comfortable with LGBT people." Part of becoming more competent, welcoming, and inclusive providers of care to LGBT individuals is to cultivate an awareness of the personal beliefs and biases we hold with respect to LGBT individuals and their families. Cultivating self-awareness is ongoing work no matter our background.

PCC demands we not make assumptions about the person in our care, but instead be open to learn about the person from the person. The benefits to doing this work extend beyond LGBT older adults. Respect, openness, decency, and kindness, which are essential to PCC for LGBT older adults, should be practiced in every PCC encounter. These acts can catalyze and cultivate healing and create healthier, happier environments and organizations that benefit everyone.

Sexual orientation and gender identity can be fluid in individuals and change over time. Individuals have the right to decide and explore their sexual orientation and gender identity. In addition, individuals should never be forced to disclose their sexual orientation and/or gender identities.

Essential to PCC is learning the person's life history. More information assists with assessing, planning, and implementing care. We want older adults to feel safe to openly communicate their individual needs, concerns, and feelings to care providers. Learning a person's life history not only provides health care professionals with important clinical information, it can also lead to a deeper, more meaningful connection between care provider and patient.

Older adults can derive health benefits from reminiscence itself. Reminiscence can help reduce depression, loneliness, and isolation (Kris & Henkel, 2017; National Institute on Aging, National Institutes of Health, & Department of

Health and Human Services, 2011; Tamura-Lis, 2017; Touhy & Jett, 2011). In skilled nursing facilities, reminiscing and life review can occur frequently and organically. Many take for granted being able to speak freely and openly about their loved ones and the lives they lived before entering the nursing home. But individuals who worry about being mistreated because of their sexual orientation or gender identity may avoid and resist reminiscing and life review with care providers and other residents. If reminiscence can reduce loneliness, isolation, and depression, it follows that for some individuals who remain vigilant against disclosing their sexual orientation or gender identity, they may experience an even deeper sense of isolation, loneliness, and depression as a result of not being able to talk freely and openly about themselves.

Over the course of their lifetime, LGBT older adults have had to navigate a world that, in various ways, has been hostile to LGBT individuals and their families (Choi & Meyer, 2016; Institute of Medicine, 2011; National Resource Center on LGBT Aging, 2015). Now they are and will be living in long-term care facilities. We cannot change the past, but we can learn from it and do the work that we value so much: promoting and fostering healing and well-being and reducing pain and suffering.

As of November 2017, the Centers for Medicare & Medicaid Services regulations require PCC. We can lead the way and encourage others to incorporate sexual orientation and gender identity into PCC. Please join me in making 2018 a year in which we strive to respect, honor, and protect with compassion the dignity of all individuals we serve, and commit to becoming more aware of and competent in providing care for LGBT older adults.

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