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Research Article

The Indigo Project: Participatory Action Research with Gender and Sexual Minority Survivors of Elder Abuse

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Abstract

Though research suggests that older adults belonging to gender and sexual minorities (GSM) are at greater risk of abuse and neglect, more needs to be done to investigate this situation, provide solid data, offer support to survivors and better inform those providing services. This article reports on a participatory action research project in which nine older adults with lived experience of abuse were interviewed, as were the seniors' programmer from our community partner organization and a trauma counsellor who supported our participants throughout the project. Participants were interviewed at least twice, often more, and the resulting interview transcripts were edited with the help and consent of the participant concerned, to form narratives which were content-analyzed. The goals of the project were to raise awareness of the underreported issue of abuse of elder GSM individuals, to consider how elder abuse might both differ and look the same as it does in the mainstream population, and to offer mental health supports and safe spaces for healing for our participants. This deep dive into lived experience illuminates how homophobia and transphobia (both historic and contemporary)

play out in subtle and complex ways. We conclude with recommendations for researchers and care/service providers.

Keywords
Elder abuse; LGBT+; gender identity; sexuality; narratives; trauma; homophobia; transphobia

1. Introduction

There are a number of factors that put gender and sexual minority (GSM) older adults at greater risk for elder abuse than their mainstream age contemporaries. They are less likely to be married, more likely to live alone, and less likely to have children or find their children supportive [1]. They are at increased risk of mental illness [2, 3], depression, and disability [1] and more likely to have experienced trauma and to have abused substances [4]. They are at greater financial risk, because of discriminatory access to legal and social programs and lifetime disparity in earnings [4].

GSM elders have typically lived through times in which homosexual, nonbinary, and transgender identifications were criminalized and pathologized. The oppressions they endured have included incarceration, conversion therapy, banishment from their churches and families, social exclusion, physical violence, loss of jobs, housing, and custody of their children [5]. Many commentators have reported that marginalization of this nature has led to feelings of shame, self-stigma, and low self-esteem for GSM individuals [6]. As GSM elders experience physical decline and increased dependence on others, some of whom may not understand or accept their identifications as GSM, these feelings can only be compounded. As Cook-Daniels ([7], p. 543) has suggested, "the history of social and interpersonal discrimination, violence, and trauma that LGBT elders have experienced simply adds to the ways in which they can be threatened or manipulated by abusers." By definition, elder abuse is about the misuse of power, thus those who believe that they are 'less-than' can be said to provide prime targets.

Despite these situations, GSM older adults remain a largely invisible population. There is a dearth of data on elder abuse among GSM elders and much of the research that does exist is speculative. Few studies have engaged with or consulted GSM survivors of elder abuse in order to investigate and detail their lived experiences. Our project addressed this gap in order to better understand how abuse manifests in the lives of GSM older adults.

Throughout this article we use the acronym GSM to include all those identifications covered by rather more unwieldy acronyms such as LGBTQ2SA+. We define elder abuse using the National Initiative for Care of the Elderly's (NICE) definition as the "[m]istreatment of older adults…within a trust relationship" [8] including both actions and behaviors or lack thereof. NICE lists five main forms of elder abuse: physical, emotional/psychological; financial/material; sexual and neglect – all of which may be experienced by both GSM people and those who identify as heterosexual and cisgender. As to the term 'elder,' this is variously defined in the literature and by elders themselves; in our study, all participants were over the age of 60.

The Indigo Project built on an earlier project conducted by three of our authors *Raising Awareness and Addressing Elder Abuse in the LGBT Community: An intergenerational arts project* [9]. In this initial project, the researchers worked with a team of GSM youth and elders to teach

them the skills required to produce posters and videos that became the first informational materials about elder abuse in the GSM community to be published in Canada. Our literature review at that point revealed a paucity of research on the topic, although growing interest in the topic was subsequently demonstrated by the many requests the researchers and production team received for copies of the materials produced (which were distributed free of charge) and for trainings and workshops. There has been strong readership (currently over 1500 reads) of our article describing the project [9], and the team received a request to contribute a chapter to Phelan's book, *Advances in Elder Abuse Research*, which we duly provided [10]. As we continued to reflect upon this initial project and its outcomes, we concluded that the next step might be to interview GSM individuals with lived experience of elder abuse, with a view to publishing their stories in a book that might be accessible to practitioners and lay people as well as academics.

We believed that it would be important to support our participants through the course of the interview process, since disclosure of past trauma can be highly triggering. *QMUNITY*: *BC's Queer, Trans, and Two-Spirit Resource Centre* is a non-profit organization that provides programming, resources, and information of particular relevance to GSM seniors (https://qmunity.ca). *QMUNITY* arranged and funded free individual trauma counselling for all participants who requested it, as well as free membership in an ongoing peer support group facilitated by the same trained trauma counselor. Also, since our previous study indicated that survivors of elder abuse in the GSM community might be highly reluctant to come forward, we hoped that *QMUNITY* might help with the somewhat daunting task of finding participants.

2. Materials and Methods

2.1 Project Goals

The goals of *The Indigo Project* were as follows:

1. To find GSM survivors of elder abuse and capture their stories.
2. To offer the participants mental health supports during the retelling of traumatic events - a safe and sustainable space for healing and advocacy
3. To further raise awareness of the issue of elder abuse in the GSM community
4. To explore how elder abuse might look different, and the same, in the GSM community, as compared with heteronormative individuals and relationships

2.2 Project Rationale

Though we have long suspected that GSM elders are more at risk of being abused and/or neglected, we have not gained nuanced understanding of how such abuse plays out, and we believed that this gap might best be filled through narrative inquiry and participatory action research. Chevalier and Buckles [11] have emphasized the need for action and reflection by those with lived experiences of the conditions in which they were created, and yet the literature review we conducted revealed that hardly any interviews with survivors had been published. First hand narratives can reveal important information, not only about our own identities, but about the social, political, and domestic structures that we have inhabited and continue to inhabit. Also, the very act of telling someone 'What happened,' without interruption or judgment, can prove both healing and informative for narrators [12]. Our methodology gave us the opportunity to work alongside and

with our participants and to be guided by them in processes of coevolution. Rather than extracting data quickly, the team sought to engage participants in sociable forms of two-way dialogue between researchers and participants [13].

2.3 Recruitment

The first project (*Raising Awareness and Addressing Elder Abuse in the LGBT Community: An intergenerational arts project*) culminated in a series of townhalls in all five health regions in British Columbia. These were well attended by GSM elders as well as organizations that provide them with services. It was with some surprise that we noted that only one or two attendees approached us to let us know that they themselves or someone close to them had been abused. This ran counter to the previous experiences, over decades, of Authors 1 and 2, who not only identify as GSM, but also have lengthy histories of grassroots activism in various GSM communities and organizations. In previous outreach initiatives, they had typically found people eager to share their experiences, both privately and in public forums.

The team suspected that this notable silence might be the result of the layers of shame and stigma involved in having being abused. It might be one thing to be old, female, male, and/or transgender or nonbinary, and at the same time, to be a member of the GSM community, particularly for a generation used to being criminalized and pathologized for their gender and sexual identifications. We suspected that to then also have to admit that life choices made in the face of such discrimination led to abuse might feel just too difficult – an assumption that was amply confirmed as the project progressed. Additionally, to disclose abuse can open victims to reprisal, and indeed, four of the nine participants expressed strong fears of this possibility.

It takes courage to come forward in this context, and clearly, recruitment was likely to be an issue. We spent a great deal of time branding the project suitably before we launched it. At the prompting of one participant (Pam), we removed the word 'survivor' from the title, which she felt positioned participants purely as victims. Instead, we chose the term *The Indigo Project*, which we hoped was more neutral as it also spoke to the invisibility of elder abuse within the GSM community, which has tended to concentrate on the brighter, more positive end of the rainbow - the oranges, reds and yellows of Pride, rather than the blues and greens of sadness and bruises. Purple is also, as many readers may know, the colour worn on such occasions as World Elder Abuse Awareness Day.

We launched the project in January 2022, through emails, phone calls, and repeated social media posts, but despite our considerable outreach efforts, no one attended our first informational meeting other than the project organizers. In the end, we did manage to find nine participants, in all but one instances through the personal networks of the research team and through QMUNITY's existing clients. Four were recruited by the QMUNITY seniors' programming specialist. She had worked with each of them on an individual basis for some time and thus knew their stories. She persuaded all four of them to attend a second informational session we had organized. Emboldened by each other's presence at this event and having learned more about the project, they signed up as a bloc. Four more participants were found through the personal and professional networks of the research team, in all cases through direct individual personal outreach. Only one participant responded to our many social media posts. Seven of the nine respondents expressed significant

hesitations and concerns about speaking out, and two became extremely jittery as we approached publication of their narratives in book form [14], fearful of lawsuits and other forms of retribution.

We accepted two participants who were reporting not on their own abuse, but on the abuse of someone they knew who had been abused and had died. In one case, this was the husband of a man who was abused in residential care (Matthew), and in the other, it was a social worker assigned to an elderly lesbian (Jackie). In each case, we felt the narratives merited inclusion, because they told stories that otherwise could not have been accessed, not only because the victims were dead, but also because each would have been incapable of offering testimony at the time, since Matthew had dementia, and Jackie was very deeply in the closet. Given the secrecy and silence that surrounds abuse in the GSM community, we wished to include these important stories, especially since the narrators, Doug and Zoe, had closely accompanied Matthew and Jackie on their journeys. We suggest that both stories have important insights to contribute, and in particular, Jackie's story of the impact of living in the closet alone and at the end of her life - an experience that would otherwise have remained unrepresented.

2.4 Consent Process

As noted above, all participants who were alive at the time of the interviews (two were deceased) expressed varying degrees of hesitation about being involved in the project. The two main concerns expressed were firstly having to talk about and thus to some extent relive painful experiences, and secondly, fear of reprisal and lawsuits by abusers, both at an individual and organizational level (the latter cases involved a hospital, a private residential care facility, and a large national charity). We also note that in three cases (FlyGirl, Bruce, and Pam), our participants believed that they might be seen as betraying their GSM communities by speaking up about the abuse that they had experienced.

With regard to talking about painful matters, including abuse, the authors believe that a significant factor in addressing these concerns was the free confidential counseling offered to participants. The four survivors who availed themselves of this opportunity all felt that it was important to their senses of security and trust during the process. The three participants who did not participate in the free counseling were all known to Author 1 for many years before the project began through work on other activist projects. In this regard, Author 1 might be described as embedded in the community she researches thus earning trust because of shared goals with regard to social justice work (known as an 'organic intellectual' by some critical theorists). Finally, the research team agreed that the project would operate from a position of total acceptance of survivor testimony during both the interview and editing processes. During the entire research process, we were careful not to question, even implicitly, the veracity and accuracy and relevance of the testimony offered.

The research team went well beyond the requirements of our institution's ethical guidelines in order to preserve anonymity and were careful to advise participants of the extra steps we had taken. As well as using pseudonyms, we changed other key details that might betray identity, such as the occupation, race, and nationality of both abused and abusers, and the geographical location of many of the events described. Author 1 was the only member of the research team who knew the identities of the participants or had their contact information. After the narratives were accepted as final by participants, all previous data (such as interview recordings and transcripts) were

destroyed. Perhaps most importantly, our consent form built in a second level of consent, as it stated that "I consent to my story being published in an anthology of narratives by survivors. I understand that I may withdraw this consent at any time up till the work is submitted for publication." What this meant, effectively, was that any participant could go through the entire process of interviews and editing, and then at the very end, decide not to publish their story. Though this decision opened up the very real possibility that the project might eventually collapse, we felt it was ethically necessary to offer an escape route to participants who might find it just too hard to go public. At the same time, we felt it might allow some participants who were fearful of consequences to tentatively engage in the process, knowing that they could withdraw at any point. This proved to be the case.

2.5 Interview Process

In order to establish trust, continuity and confidentiality, it was decided that Author 1 should conduct all the interviews. As an experienced editor and a teacher of life writing to novice adults, among others, her skills and experience seemed relevant. The interviews were recorded on Zoom and transcribed using Otter, an online transcription service.

The authors had thought it prudent to focus entirely upon establishing trust and addressing safety and confidentiality in the initial interview, but though all participants were informed in advance that we would not be discussing their abuse in this first interview, all but one launched quickly into recounting what had happened to them, as the following extract from Author 1's fieldnotes shows:

> "Though I did glance (as unobtrusively as possible) at my prepared questions to ensure that we were covering the necessary ground, on the whole, I listened to and encouraged what can only be described as an outpouring. Several participants followed up with further thoughts and insights after the interview, with emails that began thusly 'It has just occurred to me…' and 'a couple of things have come to mind.'" All the participants who had experienced abuse first hand (two participants <Zoe and Doug> were reporting on someone else's abuse), spoke for about an hour and a half without prompting.

2.6 Editing the Transcripts

The lengthy raw transcripts were edited by Author 1 as soon as possible after each interview, using only words from the transcripts (in other words, deleting words but not adding any), following the methodology used by Traeis [15]. This process was clearly subjective, as the transcripts were reduced by at least 50% in order to make them accessible and engaging, not only for academics, but for service providers and lay readers. Author 1 then sent each participant their edited narrative, letting them know that this draft would serve as a starting point and focus for the second interview and reassuring them that they still had absolute authorial control. In subsequent interviews (usually two or three), Author 1 worked line by line with each participant to further revise their accounts. In one case (Grace), the participant opted to write her own account instead. In all cases, the final text of each narrative was approved by the participants, through many Zoom conversations, emails, and phone calls.

2.7 Counselling Support

Free professional counselling was offered to all participants by an experienced trauma counsellor hired for this purpose by QMUNITY. Their participation was kept confidential, but four participants voluntarily revealed to Author 1 that they had availed themselves of this opportunity (the same four participants who had previously worked with the seniors' programming specialist). The QMUNITY counsellor, who was also interviewed, reported that the participants told her that the impact of telling their stories was both difficult and beneficial. The same four participants participated in a peer support group established and funded by QMUNITY and facilitated by the same counsellor. The group met weekly for nine weeks. After this first cycle, which had been budgeted for through the initial grants, QMUNITY obtained additional funding to make the group a permanent program within their organization. This group is ongoing at the time of writing this article, thus contributing to the second goal of The Indigo Project: To offer the participants mental health supports during the retelling of traumatic events - a safe and sustainable space for healing and advocacy.

2.8 Analysis

Once the narratives had been finalized by each participant in collaboration with Author 1, they were circulated to the other three members of the research team. All four team members independently listed the themes that they saw emerging from the data. We discussed these at some length before we began further analysis and found a high degree of similarity in our lists, so were able to reach a strong consensus as we went forward. We next divided the stories among us according to our research interests and expertise and worked individually to produce a draft analysis of each. Author 2, for instance, has read widely in the literature on domestic abuse and couple violence, so worked with the stories told by Pam and Joseph. Author 3 is more familiar with long term care situations, and Author 4 had a particular interest in trans experiences, so worked with narratives by Trudy and Candace. Author 1 also avoided working on the narratives of participants she knew well (Pam, Joseph, and FlyGirl) to minimize interpretive bias. Once all the narratives had been analyzed in this way, we all read through them, made and discussed suggestions, and revised the analyses accordingly. This was helpful in refining and extending our reflections on the project. Next, we brainstormed a rough outline of the final chapter of the book (analysis and discussion), after which Author 1 wrote a first draft, which again was discussed and revised by all four authors.

Ethics approval was granted by Simon Fraser University's Research Ethics Board (REB) on November 26th, 2021 (#30000653) The university's ethics policy and its affiliated procedures conform to the requirements stated within the Canadian Tri-Agency *Agreement on the Administration of Agency Grants and Awards by Research Institutions*.

2.9 Funding

QMUNITY applied for, and received two small grants to support their involvement in The Indigo Project, one from New Horizons for Seniors, and one from the Vancouver Foundation. 90% of these funds were used to pay for counselling services, and the rest covered the extra administrative load imposed by the project.

2.10 Limitations of the Research

1) Our data represents a small sample and thus does not lend itself to the construction of broad conclusions.
2) Though editing down the interview transcripts made the narratives more cogent and engaging, thus increasing the impact and accessibility of the research, it also opened them to researcher bias.
3) Our participants do not include any who identify as First Nation or People of Colour, despite our efforts to recruit them.
4) The experiences of our participants do not always fall neatly into the categories of abuse as traditionally defined in the literature (physical, psychological/emotional, sexual, financial, and neglect).

3. Results

3.1 Participants

Our participants comprised two gay men, two transexual women, and five lesbians, all aged over 60.

3.2 Types and Context of Abuse

The types of abuse and context report include abuse and neglect in long term care, abuse in in-home care, financial abuse by partners, partner violence, and spiritual abuse (See Table 1).

Table 1 Types, context and nature of abuse reported by study participants.

Type of abuse	Context	Nature of abuse
Sexual abuse	In home care	Inappropriate touching
Neglect	In home care	Refusal to provide care Failure to recognize sexual orientation and provide appropriate care
	Residential care	Refusal to provide appropriate care
Emotional/psychological abuse	Intimate partnership	Death threats
	Residential care	Harassment
	Intimate partnership	Manipulative and controlling behaviour
Financial abuse	Intimate partnership	Theft of money from shared business Control over pension and shared finances
	Lesbian community	Theft of medical equipment and financial exploitation
Physical abuse	Residential care	Overprescribed & unapproved medication Rough handling
Spiritual abuse	Faith communities	Ostracism and rejection

3.3 Early Abuse

Research indicates that GSM children and young adults are more likely to be abused than their age peers [16, 17] and indeed, eight of our nine participants reported that they had been abused as children (see Table 2). All of the stories shared detailed lifelong experiences of physical and emotional violence in their families of origin, organizational oppression, sexual predation by peers and adults, suicidal ideation, and workplace harassment. Suicide is frequently referenced in terms of both family instances of suicide and suicidal ideation on their parts. Data with regard to childhood abuse were not available for the ninth participant, who was deceased.

Table 2 Early abuse experienced by participants.

Joseph	Physically abusive alcoholic father who committed suicide.
Michele	Physically abusive parents. School reported heavy bruises.
Jackie	Father who tried to force her into marriage to 'cure' her.
Donald	Not known
Pam	Very physically abusive father. Mother clinically diagnosed as narcissist. Brother committed suicide.
Trudy	Attempted suicide at 5 years old. Beaten for being insufficiently masculine. Sent for conversion therapy in teens.
Candace	Sexually assaulted throughout childhood and adulthood. Suicidal ideation throughout life.
Flygirl	Disowned by family after sister outed her.
Grace	Ostracism and dislocation within various spiritual communities. Childhood sexual abuse. Suicidal urges throughout her life.

3.4 Sense of Dislocation

For most of our participants (see Table 3) there was also an early sense of dislocation and difference. Data were not available in the cases of Matthew and Jackie, who were deceased at the time of the project.

Table 3 Sense of dislocation reported by participants.

Joseph	*I always knew I was different*
Michele	*I was asked to high school parties and dances by boys, but always avoided those encounters by making excuses*
Grace	*I knew very early that something about myself was different, but I could not have told you what it was. Around about the age of 10 or 11, I shut down, knowing that things weren't going to be safe*
Trudy	*It started very, very young that I felt other*
Flygirl	*I started to have inklings when I was a teenager, but I repressed them, of course, because I was a Christian, and Christians don't do that*

3.5 Concomitant Health Issues

Most of our participants suffered from serious ongoing health issues (see Table 4).

Table 4 Health conditions reported by study participants.

Trudy	Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS)
Michele	Late-stage ALS
Candace	Heart condition brought on by stress.
Matthew	PTSD from service in Korea. Diabetic.
Flygirl	MS
Grace	ME/CFS
Joseph	HIV positive, severe bone loss from medication

4. Discussion

In some ways, the nature of the abuse reported by our GSM participants looked similar to that experienced by the mainstream population. For instance, the two stories we heard about long term residential care and in-home care mirror many of those that came to light during the COVID-19 pandemic – neglect of basic needs, disrespect and insensitivity, isolation, and lack of attention [18]. There are similar parallels in the stories of financial and emotional abuse by partners, in terms of the gradual escalation of abuse and the 'justifications' offered. Another similarity in victims of elder abuse is the presence of risk factors for victimization, including mental and physical health challenges, attitudes of self-blame, an earlier history of abuse, and problems in domestic relationships [19].

4.1 Early Sense of Difference

That said, there were some striking differences, and one of the most notable was the lingering, subtle, and damaging impact of homophobia, transphobia, and marginalization reported by our GSM participants. Some commentators have made sense of data such as that reported in Tables 2 and 3 by suggesting that early abuse (and sexual abuse in particular) can 'turn children gay' [20]; others have disagreed, and have suggested that GSM individuals present easier and more likely targets for abusers, since they have often been rejected by their parents because of their identifications [21-24]. They are thus more isolated in their early years, and at the same time, confused about their sexual identity - all situations that can be taken advantage of by perpetrators [25]. The narratives told by extant survivors in our study amply support these latter suggestions, as our participants report an early sense of difference, parental violence and rejection, rejection of gender and sexual identities, and a sense of extreme isolation. Joseph sums it up this way: "many of us [in the GSM community] have experienced trauma…and responded to that in dysfunctional ways." He suggests that if he had "been not so socialized into living with insidious abuse and trauma," he would have "dealt with it differently." Similarly, Grace refers to "psychic wounding" that shut her down at the age of 10. "It's conditioning for self-hatred" she told us.

4.2 Residential Care

As noted earlier, understaffing and inadequate training have led to abuse of many elders, both GSM and heterosexual, in long term care institutions. That said, our study suggested that GSM individuals may well face additional challenges in such situations. Doug reported that he and his husband were subject to a "whirlwind of homophobia." Michelle told us that to openly identify as GSM puts "a target on our backs." She reported the prevalence of homophobic jokes and slights in her residential care setting and indicated that understaffing led to undue authority being handed to care aides who were much less GSM competent than her nurses. Her complaints to hospital administrators were ignored and only led to further harassment by care aides, who woke her unnecessarily, refused to take her to the toilet, and subjected her to rough handling, which is particularly egregious given that Trudy suffers from late-stage ALS and is unable to move or communicate except through her iPad.

Trudy (a transwoman) was exposed to several in-home care support staff who were both abusive and neglectful. One was openly derisive about GSM people, telling Trudy how she and her friend sought out gay hotspots to jeer at GSM people on street corners. Another repeatedly touched Trudy's genitals inappropriately, without consent, and despite her protests, and yet another refused to touch or help her in any way and lodged an unfounded complaint against Trudy. Flygirl (a lesbian) reports that her care providers fluctuated in a similar way between overfamiliarity and curiosity on the one hand, and repulsion and distaste on the other as two nurses in the hospital touched her genitals without her consent, and another flatly refused to wash "her thing." Genital contact is likely to be highly charged for a population whose identifications are constructed in terms of their sexuality and who have, in the cases of elder trans folk, sometimes experienced affordable but problematic gender affirming surgeries.

4.3 Health Care

GSM individuals are less likely to visit doctors than their mainstream counterparts, and even if and when they do, they are reluctant to admit that they are GSM [26]. Our participants shed some light on historic reasons for this mistrust. "Every adult seemed to want to destroy me," Trudy told us, "…the police, the doctors, my parents." She was sent to a psychiatric unit twice a week until she was 18, where she was subjected to aggressive and demeaning conversion therapy.

Suspicion of the health care system was reinforced for our participants during the AIDS epidemic. Doug reported that "From 1990 until 1994, I worked for AIDS community hospice in LA. It was emotionally exhausting, and it gave me a deep mistrust of the health care system, and the way that people in the straight world can treat us." Michele, a lesbian, also recalls "the ways in which gay men were sidelined, marginalized, and mistreated [during the AIDS epidemic]." Like many trans individuals, Trudy found it difficult to access gender affirming surgery, and ended up going into debt in order to visit a "very shady doctor" who seemed interested only in getting paid and fraudulently faked the necessary paperwork. When she developed a vaginal infection, Trudy was stranded in a tiny room in New York, with no support or aftercare - probably a fairly typical story at that time. Despite Trudy's objections, her current doctor insists on outing her as a "transwoman" when referring her to specialists, even when her gender identity is not significant in terms of her medical care.

4.4 Faith Communities

Freeman and Vaillancourt [27] define spiritual abuse as "the erosion or breaking down of one's cultural or religious belief systems" and again, this is not restricted to the GSM elder population. Once again however, spiritual abuse may have a greater impact on GSM individuals, since they are often required to search for support and recognition from outside their biological families. Grace argues that spiritual abuse is particularly destructive for GSM individuals since it "assaults the most profound levels of being, impeding healthy emotional development and maturation, the capacity for rewarding wholesome relationships with oneself and others; and generates destructive forces within the person who can no longer connect with the deepest gift of life – truth and beauty of their own being gifted from the Creator." She provides a compelling example - rejected by many faith communities during her formative years because she identified as GSM, she felt "blamed, scapegoated, labelled, judged, and abandoned." When she finally gained admittance to an open and affirming church, she was publicly shunned by one member (who was a closet lesbian), and reported that this caused her to "shut down for the next 10 years." Grace ends her narrative with the following words:

> *The early homophobic indoctrination I received was so deep, and not just from my faith tradition, but from our larger culture. I call it cultural conversion, entirely kindred to conversion therapy. The damage it did was as profound as any type of long-term sustained abuse.*

4.5 Cultural & Systemic Violence

4.5.1 Open Homophobia and Transphobia

According to the literature, GSM older adults are at the highest risk for abuse and neglect by caregivers [28], a situation that Frazer [29] suggests may be caused by homophobia. Our participants did report instances of outright homophobia and transphobia during their senior years, though these were actually fewer than we had expected. As mentioned earlier, Trudy's doctor unfailingly identifies her as a transwoman when referring her to other practitioners, even when her gender identification was of no significance, and even after Trudy had complained: "I asked her, 'Please don't do that. I get really bad service from them when you say that.' But she said, 'Well. They might need to know. It might be important'. She's stopped doing it now but only after quite a few years. That's what you get all the time." As also mentioned, Trudy's in-home care provider constantly tells her stories of how she and her friends travel to gay communities in order to "laugh at them on street corners."

4.5.2 Covert Prejudice

What was much more common in the narratives told by our participants was a sense that although the abuses and neglect that they experienced probably stemmed from homophobia and transphobia, these remained covert. It seems likely that since the rights of GSM people are (currently) legally upheld in Canada, so that overt discrimination can now involve legal consequences, service providers are more cautious about naming their prejudices. That said, though hatred and suspicion of GSM individuals might have gone underground, they have not gone away. Recent anti-gay and anti-trans movements in the US suggest that an extant anti-gay/trans

undercurrent was waiting to emerge, and some commentators [30] suggest that even liberal Canada's anti-LGBT movement is currently emboldened by this re-emergence.

Michelle and Doug both reported that the cultures within their residential care facilities were homophobic. Michele noted that homophobic jokes were frequent and remained unchecked, and one of her male aides told her that she "must hate all men" because she is a lesbian. Doug noted that all visibly gay staff members quickly disappeared from the care home within months of his husband Matthew's arrival, that he and his husband were the only openly same sex couple in the home, that they were never officially welcomed or shown around the facility, that his partner's power of attorney was 'lost' and never found, and that his first encounter with administrators was accusatory and highly negative, as in front of 11 administrators, the General Manager of the facility accused Matthew of being "racist, misogynist, and bigoted." Doug was astonished, since Matthew had excellent relationships with women (including his ex-wife) and had been arrested in Alabama for protesting for civil rights. Initially, Doug wondered if Matthew's incipient dementia had worsened and led to his making inappropriate comments, but saw no signs of cognitive decline in his husband, and said that in any case, "surely the staff would have made some allowances for an elderly veteran with PTSD and the beginnings of dementia?" "My gut told me," Doug said, "that this attack was caused by a whirlwind of homophobia – part of a deliberate plan to get us out of there, though no-one made explicitly homophobic comments."

This 'gut sense' of prejudice at work pervades the narratives. "It was for sure homophobia," Joseph said of the police who intervened when he reported death threats from his partner. "They didn't want to get close to me. They just didn't know what to do about it. I have all these tattoos, which makes me suspect and unreliable*. I just felt it*. I knew it. When they looked at me, they almost smirked" (italics mine).

These reports of covert homophobia and transphobia point to a productive area for future research, and they are certainly something that anyone providing services for seniors might usefully consider in their practices. The point that health care and other service providers might consider is not so much the accuracy of these suspicions, which can likely never be proven or disproven, but the way in which they adversely impact GSM older adults [31]. For all marginalized populations, subtle and unspoken discrimination is difficult to address, without being accused of hypersensitivity, yet difficult to ignore, given the frequency of actual microaggressions. Victims are left to doubt their interpretations and live with the knowledge that though they believe that they have been victimized, there is nothing they can do about it, thus reinforcing their sense of powerlessness and invisibility.

4.5.3 Heteronormativity and Internalized Homophobia

Heteronormativity can be described as a context in which GSM and trans identifications remain invisible because no one thinks about them. For instance, Jackie, a lesbian whose partner had recently died, was assigned a Greek social worker, because she was Greek. Though this seems like a sensible, and even sensitive, decision, it is made in the context of Jackie's deep internalized homophobia, which has led her to conceal her lesbian identity – she begs her caregiver, Zoe, who reported on Jackie's story, not to say the word 'lesbian' out loud, preferring to be called "an old butch." Zoe, a sympathetic social worker and herself a lesbian, finds out that the elderly Greek male assigned to Jackie reminded Jackie of her own Greek father, who tried to force her into a heterosexual marriage.

Jackie's other caregivers failed to notice clear signs that Jackie was a lesbian. Photographs of Jackie and her partner lay in plain view, and her dead partner's clothes still hung in the closet. If a client or patient is afraid and reluctant to reveal their sexual or gender orientations, assumptions of heterosexuality serve to compound their invisibility. Failure to 'pass' (as heterosexual and cisgender) lead to discrimination (for instance, the police are suspicious of Joseph because of his many tattoos), while the ability to pass leads to an assumption of heterosexuality or being cisgender. Again, awareness of these complicated and subtle issues may go beyond standard and superficial trainings in GSM competence, but they have great impact on the ground.

For this particular generation of GSM elders, internalized homophobia and transphobia such as Jackie's are of special significance, since they have lived through times in which they were considered sick, insane, and dangerous. Even though there is no causal link between child predation and identifying as GSM, Trudy told us that she walks quickly away when children in the playground near her home come to pet her dog, fearful that she will be accused of trying to lure them. Although she defines as lesbian, Grace has not disclosed this to some of her friends and has never been confident enough to enter a same sex relationship. Candace was so afraid of being identified as homosexual that she shunned a best friend in childhood when peers accused the friend of being gay. Candace also lived at odds with her biological masculinity for 70 years. She went window shopping at women's clothing stores, but was unable to come out as transgender, frequently contemplating suicide, until she found support and came out as transgender at the age of 70. "You were taught to be afraid of them [GSM people]," Candace said in her interview. "I spent so much of that time suppressing anything in that direction, just to try and keep myself safe from that happening." "My real regret is not coming out much earlier," she reported.

It seems likely that there are many people like Candace who are discouraged by systemic and cultural norms and thus remain unable to take the brave step of coming out, but live invisible lives of quiet desperation. This self-imposed silence poses a difficult and perhaps insurmountable problem for researchers, as became clear in this study, but we know that such survivors still exist. We can only hope that our project might indicate directions for further research and similar projects that might offer them safe places to come forward.

4.5.4 Other Considerations

Minority Status. In her work on violence in lesbian relationships, Ristock [32] notes that many women, especially the younger or more newly-out partner, remained in their relationships to be able to remain in contact with the lesbian community. In this sense, there might be increased dependency on partners and increased difficulties in finding social support. Also, they are under pressure to 'keep up appearances,' since their relationships are under extra scrutiny. Pam reported a "need to look like a model of a loving relationship." Indeed, she hands over control of her money to her partner Meera to reassure Meera's parents of her honest intentions, since Meera had suggested that they would suspect Pam's motives. Flygirl believed that she could not speak negatively about the lesbian community, because it would be too risky: "I wouldn't ever talk openly about my disillusionment with lesbian culture. It's our dirty secret." Historically, GSM culture has focused on celebrating youth and avoided topics such as aging and abuse.

Support Systems.

> I have no bloodline of queerness: no family tree, no "alternative" ancestral line to account for my queerness. There was an utter lack of queer role models from whom I could learn, and no queer bodies on whom I could lean, I was the only one. I am the only one: the only queer person on both sides of my parents' families. Further to that, there were the homophobic jokes, innuendos, and slurs in music videos and movies I watched and at school (in which, I too, participated), and the 'flamboyant gay man' impressions my father occasionally performed at the dinner table. It has made for a confusing, unsettling and persistent experience of attempting to figure out and be comfortable with who I am, to make sense of my sexuality and gender identity.
>
> Reid, 2014 [33]

Joseph's mentors are older men who introduced him to sex. He does not regard this as predation or abuse, and we respect his testimony in this regard. That said, at the very least it opened him to the possibility of risk and exploitation. Trudy's visits to gay bars led to police intervention and an attempt at conversion. Grace was frequently rejected by various churches, though she was desperate to find Christian community. Though many GSM people do depend upon 'chosen family,' Flygirl's testimony details corrosive lateral violence within her lesbian community.

Resilience. All of our participants did draw upon various forms of support, albeit in unlikely spaces, and often because of their ingenuity and willingness to take risks. Trudy ventured out to gay bars when she was just a teen, finding comfort in "watching the people come in." Even though she didn't engage with other GSM individuals, it helped her to know that she was not the only one. Joseph takes this a step further as he heads to the library to research where gay men meet each other, then finds a likely restroom in his home town and has sex there with strangers, some of who become valuable mentors and provide him with an entry to gay life. Rejected by battered women's support services, Pam asks her friends for help. Jackie is terrified of identifying as a lesbian, but can claim an identity as an old school butch. Despite many rejections by faith communities, Grace eventually sought out an Anglican priest "who is also a strong ally for LGBTQ people." Emboldened by watching *The Danish Girl* and *Call the Midwife,* Candace found the courage to transition at the age of 70. Matthew was eventually removed from his abusive and neglectful residential care home by his loyal and loving partner, who took care of him until his death. Of course, this is not true for many victims of abuse, and here we acknowledge the likely reality that there are many who are abused, unidentified, unsupported, and alone.

Organizational Support. Grace, Candace, Michele, and Trudy were all members of the facilitated peer support group established by QMUNITY, and Flygirl was also supported by this organization at one time. This is perhaps not surprising, given that all but one (Flygirl) were recruited as participants by the seniors' programmer there. We suggest that peer and/or organizational support is crucially important, both in terms of facilitating and encouraging disclosure of abuse, and finding support in healing from it. As the group facilitator reported in her interview: "This group became more solidified and more connected and more supportive of one another. They were reaching out to one another way outside of group…they really started to look out for one another." All four of the original support group continue to meet, and the group has now been opened to other survivors. Given the paucity of support for GSM elders who have experienced abuse, it seems that

organizations like QMUNITY are vital, though often unacknowledged in the literature. We would not argue that all studies into GSM abuse should necessarily provide free counseling and peer support to participants, since this would be impractical for many projects and is probably unsuited to most quantitative studies. Given the lack of extant research, the last thing we would wish for is to offer further obstacles. That said, it was highly successful in supporting our participants through sharing their first-hand accounts, and might be considered as best practice.

The Indigo Project. The Indigo Project as a whole was itself viewed as a source of support for some of our participants. Below are extracts from some of the emails Author 1 received after the interviews.

- "Thank you for your work, Claire. I've felt some healing this week." Grace
- "If others can benefit from our stories, I am proud to have taken part." Candace
- "The support the project provided has given me the chutzpah to get up the nerve to file an incident report with the police. On the physical abuse." Michele
- I've learned a lot from doing these interviews, about myself and about my relationships. Joseph

Although it may be difficult to quantify the benefits of simply telling one's story from start to finish, without interruption, to an attentive and nonjudgmental listener, we suggest that it was both educational and empowering.

5. Conclusion

GSM competent training is essential, particularly for 'on the ground' care providers, such as residential and in-home care aides, who are often low paid and lack nuanced awareness of GSM issues and rights. Since staff turnover is particularly high in this sector, training should be ongoing and it should include education around the histories and rights of GSM people in Canada, the extra sensitivities of GSM individuals with regard to assistance with personal hygiene, and the special medical needs of transgender clients. Those working with older adults should be sensitive to the possibility that their clients might identify as GSM but be reluctant to share such identifications, taking care not to assume that they are heterosexual, particularly during intake. Intake questions should always include the possibility of GSM identifications. These can be as simple as asking questions such as "Do you have sex with men, women, or both?"

Given that GSM clients are often invisible in the largely heteronormative settings of doctors' offices, hospitals, residential care settings, or adult day care, it is particularly important to maintain a visibly GSM positive climate. Visible signage such as rainbow stickers and inclusive mission statements are an important first step, but administrators should also consider ways to go beyond these, even when they believe that all their clients are heterosexual or cisgender. The steps taken might include inviting speakers, celebrating events such as Pride and the International Day Against Transphobia and Homophobia, making books, films, and images of GSM history available, encouraging storytelling projects that forefront the narratives of all residents, including GSM people and members of other minorities. There should be zero tolerance for homophobia and transphobia. This should include zero tolerance for homophobic and transphobic jokes, slights, and slurs. Language used in trainings, bulletins, communications and signage should be inclusive of gender and sexual minorities.

Our study suggests that there is a pressing need for more projects that offer counselling, support and advocacy for GSM survivors of elder abuse. There is often no specific process for GSM victims of abuse to report or disclose their situations and few GSM competent resources. This situation might be helped by more robust alliances between health care providers and GSM organizations, who can both offer GSM competence training, identify those at risk for abuse, encourage them to seek help, and offer peer support groups such as that pioneered in this study.

We suggest, with Grace, that expanding the commonly used definitions to include spiritual or cultural abuse might be justified, given the historical context experienced by our participants.

Further research is called for with regard to the GSM populations. We recommend that these should include quantitative studies that determine the extent of the abuse of GSM people and use a range of inclusive terminology; studies that focus upon reaching invisible, closeted, or hard-to-reach minorities; studies that capture lived experience through such practices as storytelling and photo/video narratives. More outreach should be conducted to GSM, BPOC, and Indigenous minorities, including researchers within those communities, cowritten grants, outreach to community organizers and organizations, and the inclusion of non-academics and activists. Finally, further research is necessary in order to determine the impact of homophobia and transphobia on younger GSM people. Given that they have reached maturity in times when they are better protected by legislative and cultural changes, will future generations be at less risk for abuse? Table 5 (below) offers a summary of our recommendations.

Table 5 Summary of recommendations.

Summary of Recommendations
• GSM competent training should be ongoing and include education about the histories and rights of GSM people and their special needs and sensitivities in the health care system
• Intake materials should include easy options for people to identify as GSM and intake staff should never assume heterosexuality
• GSM positive climates in facilities such as hospitals, doctors' offices, and long-term care facilities should include GSM positive signage, speakers, historical materials, Pride events, and celebrations of GSM culture such as Pride
• There should be zero tolerance for homophobia and transphobia, even when it is covert or subtle or 'joking'
• Researchers conducting projects on GSM elder abuse should consider the importance of providing counselling support and forming partnerships with GSM organizations
• Specific reporting processes for GSM elders who are abused should be implemented both locally and federally
• Religious abuse should be included in the categories of abuse and considered especially important for GSM individuals
• Further research is needed into elder abuse in the GSM population, both quantitative and qualitative. Outreach is needed to GSM, BIPOC and Indigenous people, who should be considered partners in these research processes

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Author Contributions

Robson conducted the interviews and worked with the participants in constructing the narratives. She also took the lead in data analysis and interpretation, and in project write up. Marchbank and Gutman assisted with data analysis and interpretation and reviewed and contributed to the manuscript.

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Competing Interests

The authors have declared that no competing interests exist.

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