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Research Article

What Do We Know about an Invisible Issue? Results of a Scoping Review of Elder Abuse and Gender and Sexual Minorities

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Abstract

Elder abuse occurs to older adults who are members of gender and sexual minorities (GSM). Whilst most of that abuse is similar to that experienced by their heterosexual and cisgender peers GSM older adults face particular vulnerabilities due to their life experiences and changes. In this article we report on our findings from a literature search and knowledge synthesis, conducted as part of a larger project to inform Canadian policy makers working to eliminate gender and sexuality-based inequalities. The review included literature on GSM and the experience of elder abuse produced in the previous decade (2013-23). A six-month scoping review was conducted via a staged approach including discovery layer searches; database specific searches; Google scholar and citation examination searches; and general Google searches.

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Keywords
Elder abuse; discrimination; vulnerabilities; GSM; older adults

1. Introduction

In this article we report on our findings from a literature review and knowledge synthesis conducted as part of a larger project to create a range of knowledge syntheses to inform Canadian policy makers working to eliminate gender and sexuality-based inequalities. Our project sought to seek out and engage with literature on GSM (gender and sexual minorities) and the experience of elder abuse produced in the previous decade (2013-23). Three of the five members of our team (Marchbank, Robson and Gutman) have been working together since 2015 to raise awareness of elder abuse amongst GSM populations and this has resulted in several publications [1-3]. Given the earlier work we were already aware that GSM older adults face particular vulnerabilities that can make them experience elder abuse in ways that are specific to their communities and that can present additional barriers to their health and well-being. With increasing rights for GSM persons over the past two decades a corresponding increase in literature has occurred which we explored to draw out themes and findings.

1.1 What We Knew Going In

Prior to 2013, GSM older adults were often described as an invisible population both outside and within the GSM community [4, 5]. This invisibility is multiply determined and based in stigma and prejudice [6] as well as concealment [7-9]. At the same time, GSM individuals are at increased risk for elder abuse [6, 10, 11], neglect [6, 10], and exploitation [6]. They also report the negative effects of heterosexism [12], of feeling guilty when requesting support [13] and of experiencing loneliness at greater rates that their heterosexual peers [14]. As such GSM elders are more likely to live alone, less likely to be partnered, and far less likely to have children, or if they do, to find them supportive [15] - all risk factors for elder abuse, neglect, and exploitation [6, 10, 11]. In addition, GSM individuals are more likely to have experienced various forms of trauma and to have abused drugs and alcohol, also known risk factors for elder abuse [1].

When GSM individuals do experience abuse, shame, and a desire to be seen as ‘normal’ may make them reluctant to report it, while fear of disclosure and/or homophobia are thought to keep many abused GSM older adults from seeking help and services [10]. The problem is exacerbated by the fact that elder abuse, along with most aspects of aging, is insufficiently discussed in GSM public forums or media [12]. The reasons for this absence may include ageism in the GSM community and a tendency for GSM couples to conceal problems in their relationships, since they have faced societal and family criticism for being in same sex relationships or identifying as trans.

In addition, Cahill et al. [13] note that GSM older adults face isolation, a lack of social services and a deficit of culturally competent service providers. Further, in the GSM community older adults are three times more likely to live alone than their heterosexual counterparts [5]. They also report higher rates of loneliness and isolation, especially in rural areas [14].

2. Methods

Due to the wide-ranging and non-cohesive nature of the literature on this topic that make a traditional systematic review of limited value [16], our methodology and work plan centered on a 6-month scoping review. The scoping review process relied on the staged approach set out by Arksey and O'Malley [17] and further refined by Levac et al. [18] and Colquhoun et al. [19].

We hired two Master's level Research Assistants (RAs) who we trained on scoping review process and procedures and supervised whilst they utilized four search strategies: (1) discovery-layer searches (2) database-specific searches, (3) Google Scholar searches and citation examination, and (4) general Google searches. All four types of searches were necessary in order to achieve literature saturation (i.e., the point at which no new literature emerges in searches).

2.1 Discovery Layer Searches (Months 1-2)

A discovery layer is a software application that is used to conduct multiple searches across article databases and other library holdings. Not limiting the scope to particular databases to start allowed the interdisciplinary shape of our particular topic to emerge. Sample search phrases include: (elder OR "older adult" OR senior) AND (gay OR lesbian OR transgender OR bisexual OR GSM OR queer OR "sexual minority" OR "gender minority") AND (violence OR abuse OR neglect). Search terms became increasingly nuanced as the scope of the literature took shape and new keywords were determined. To verify that the relevance criteria was being properly applied team members duplicated searches to compare results.

2.2 Database-Specific Searches (Month 2)

For our topic, we began our database-specific searches with two health databases: CINAHL and MEDline. By the end of the project, 42 databases were searched.[1]

2.3 Google Scholar Searches and Citation Examination (Month 3)

We used Google Scholar to seek grey literature. The same search terms were used, but updated for the proper way to search within the Google environment (i.e. no AND OR NOT Boolean logic). Google Scholar also allows for citation chaining - the practice of seeing who cites a particular document - which allowed our RAs to find the most recent literature in a subject area, including materials not yet available via library systems. The RAs added relevant literature to Zotero and the Google Spreadsheet.

[1] These include: PubMed, JSTOR, Project MUSE, Sociological Abstracts, Taylor & Francis, Proquest Dissertations & Theses, SAGE Journals, Web of Science, Wiley, Social Sciences Citation Index, Canadian Newstream, NexisUni, Proquest Newspapers, and various EBSCO databases (Academic Search Premier, AgeLine, Alternative Press Index Archive, America: History & Life, Anthropology Plus, Applied Science & Technology Index, Bibliography of Asian Studies, Bibliography of Native North Americans, Business Source Complete, CINHAL Complete, Communications & Mass Media, Criminal Justice Abstracts, eBook collection, EconLit, Education Source, Environment Complete, ERIC, General Science Abstracts, Global Health, Humanities Source, International Political Science Abstracts, Maclean's Magazine Archive, Military & Government Collection, Political Science Complete, APA PsycArticles, APAPsycInfo, Social Science Full Text, SPORTDiscus, Women's Studies International).

2.4 Google Searches (Month 3)

While Google Scholar returned some grey literature, pilot projects involving GSM elder abuse, as well as some advocacy group and governmental reports can only be found using general internet searching. Our RAs explored the first 300 search results in a general Google search for resources related to elder abuse amongst the GSM community. They also conducted an advanced Google search for filetype: PDF, which limits the search to PDFs only. This technique helped surface grey literature reports.

2.5 Search Findings

The search for data resulted in the collection of 76 records with 61 within the date range of the past decade. Of all records found 34 were academic journal articles or academic chapters in books. The 'grey' literature comprised of nine reports from organizations [6, 7, 20-24]; four websites and one training module. A further 12 newspaper articles were also found. In total 21 records utilized primary data, of these five were out of our date range. As such, only 16 records were found from the past decade that collected and reported on primary data [25-38]. Other records often utilized secondary reporting or reported on methodology of studies rather than the findings regarding GSM elder abuse.

3. Definitions and Context

The definition of elder abuse used in this knowledge synthesis was developed by the National Initiative for Care of the Elderly (NICE) [22], which views it as any '[m]istreatment of older adults [referring] to actions/behaviors or lack of actions/behaviors that cause harm or risk of harm within a trust relationship' [22]. NICE (2015) employs five subcategories.

- Physical - 'Actions or behaviors that result in bodily injury, pain, impairment or physical distress'
- Emotional/Psychological - 'Severe or persistent verbal/non- verbal behavior that results in emotional or physical harm'
- Financial/Material harm - 'An action or lack of action with respect to material possessions, funds, assets, property or legal documents, that is unauthorized or coerced, or a misuse of legal authority'
- Sexual - 'Direct or indirect sexual activity without consent'
- Neglect - 'Repeated deprivation of assistance needed by an older person for activities of daily living.'

A note is required on the variety in the acronyms contained in this article. Whilst 2SLGBTQIA+ (Two Spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual plus) is the most inclusive not all studies contained all these identities. The acronym used by the study under discussion is employed.

The context for many GSM older adults is a lifetime experience of violence, abuse, and hate crimes, extending from child abuse to end-of-life care [24, 34, 39]. Compared to their cisgender/straight counterparts, gender-diverse and LGBT older adults are more likely to experience socioeconomic barriers that prevent healthy aging and put them at risk of abuse [39, 40].

The forms of abuse experienced by GSM older adults include physical harm [27, 28, 41, 42]; psychological abuse [27, 28, 41]; neglect [25, 27, 43]; including self-neglect [44]; and fear of neglect if sexuality disclosed [35]. Financial abuse was also found [27, 45, 46]; and sexual abuse was included in several studies [27, 47, 48]. In addition to the standard forms of abuse the literature reports that older LGBT adults express a fear of entering into long term care (LTC) due to fears of discrimination [49], others have experienced polyvictimisation [50]; whilst others report unique and specific risk factors based on being LGBTQ [51, 52]. Micro aggressions were also found to be present [5, 53].

Analysis of the Canadian Longitudinal Study on Aging (CLSA) data by Gutman et al. (2023)[29] is one of the first to statistically demonstrate higher prevalence of elder abuse among LGB compared to heterosexual people, with lesbian and bisexual women experiencing the highest prevalence of financial and psychological abuse. Physical abuse was the least common but experienced by gay and bisexual men at a rate of 2.4%, almost double the rate for heterosexual men. This is not surprising as compared to their age cohort of heterosexuals LGB older adults are more likely to be socially isolated and live with physical and mental health challenges [2].

4. Terms

It is only in recent years that a consensus has been reached on what behaviours are included in the phrase 'elder abuse' [46]; the Canadian definition is 'actions/behaviours or the lack of actions/behaviours that cause harm or risk of harm within a trust relationship" [46]. Brotman et al. [7] raise the question of including homophobic abuse as a separate category of elder abuse and Westwood [53] provides three categories for LGBTQ+ elder abuse: elder abuse of older people who are LGBTQ+; homo/transphobic abuse towards LGBTQ+ folks who are also older; and abuse of people because they are both older and LGBTQ+. Robson et al. [34] do not recommend a separate category as being a gender and/or sexual minority (GSM) does increase risk of abuse but not what is actually perpetrated as abuse. Nonetheless, they do see an argument for adding spiritual or cultural abuse to the definition [34].

An issue affecting the ability to synthesis knowledge on GSM elder abuse is the differing terms used by each study. Although we employ GSM we recognize that other studies are not as inclusive, for example Gutman et al. [29] do not include transgender nor non-binary individuals as separate groups because the sample sizes were too small. A search for studies on asexual individuals confirmed the earlier findings of Cook-Daniels and munsen [11] that there is insufficient data to analyze this group. We therefore use the acronyms of each study discussed as appropriate.

Another issue affecting synthesis is the lack of agreement on who counts as an older adult. There are no global or national age aggregates for older adults in the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community. This includes the US, where the discourse about older LGBT has been based on estimates from the Centers for Disease Control and Prevention (CDC) and state-based figures [51-53]. Based on the patterns we observed in the literature, we describe the state of the knowledge regarding the use of specific ages like 50+, 55+, 60+ and 65+.

The rationale for the variations differs, ranging from unique life course experiences, gender differences, generational gaps, and self-identification among other reasons. For example, Gutman et al. [28] argue that the unique trauma associated with the aging process of trans persons requires setting a lower cut-off age like 55+. Similarly, Butler [54], in her book chapter on LGBTQ older adults, substantiated that a history of discrimination, criminalization, and stigma has limited researchers'

access to older LGBTQ research participants. Hence, the lower age limit pervades the older LGBTQ literature.

Also, in the US, a generational perspective was presented to account for the differences in the rate at which persons aged 50-64 compared with those age 65+ identify as LGBT [40]. In the same study, within similar age categories, more men than women identify as LGBT. Caceres et al. [55] observed that most study participants are less than age 65, meaning that fewer older-old LGBT were captured in the research. The authors recognized the influence of intersectionality and unequal access to long-term care services and supports due to racial differences. They remarked upon the potential for unequal access to care and support resources limiting the research participation of people older than 65 years old.

Robson et al. [1] noted that 'self-identification' as being 'old' influences the extent to which variation occurs in the classification of actual age groups that qualify for older LGBT research. The lowest age classification for GSM elders in the literature is 50+. Hawthorne et al. [45] in a systematic review of the structure, experiences, and challenges of social support for LGB individuals, argued that while 50 is a younger age than is often used in the general older-age literature, this age has emerged as a common approach in the literature on older LGB adults. In their narrative review of articles predominantly from the US, there were variations regarding the age categories in the LGBT community. Older adults' cut-off age was mostly 50+, while there was scant inclusion of 60+ and 65+ [39]. Also, in Westwood's commentary, age 60+ was the reference age for describing LGBT older adults [37]. However, Westwood reflected on how a study in the trans community in the US accommodated participants who are aged 50 and over [37]. Similarly, the 50+ age benchmark was observed in a study conducted in the LGBT community in South Africa and Maine, US [33, 45]. Besides, a study in the LGBT2S community in Ontario, Canada aligned the age grouping for older trans people with the 50+ criteria [30]. Additionally, Cooks-Daniel and munson [11] reinforced the 50+ age aggregation. In their study of sexual violence, elder abuse, and sexuality of transgender adults, the cut-off age for participation was age 50+. Overall, although Bleomen et al. [25] recognized that a few studies describe older adults in the LGBT community as being 60+, their study participants on the experiences of elder abuse and neglect in the US were aged 50+. Also, in a systematic review, the inclusion criteria for the reviewed studies were 50+ [56]. In the same way, the narrative by Connidis and Barnett [57] on the nature of relationships in marriage and same-sex unions employed 50+ for their study. However, they cited examples of older LGBT adults starting from 60+ years. Several studies did not indicate any age range referring only to 'older' [58-60]. However, to extend the discourse on the 50+ age mark, Gutman et al. [28] chose 55+ as the cut-off age and this is the age for accessing senior programs in British Columbia [61]. The age 55+ was determined based on the disproportionate outcomes of the aging process among marginalized older adults [28]. Similarly, Elder Abuse Ontario (2018) reports also recognized the use of the 55+ age as the marker for trauma-related research among older LGBT individuals [42]. In a UK study on gender, sexuality, and housing/care preferences among older LGB individuals' participants aged 58+ were recruited into the study [37].

In the USA, the CDC classifies older adults as persons aged 60 and above [51] perhaps reflecting earlier studies which also use this category [58, 59]. In Australia, research on residential and home care services experiences of lesbian and gay participants defined older members as people aged 60+ [36]. The review of *Aging and Mistreatment: Victimization of Older Adults* in the United States aligned with the idea that older age in developed and developing countries starts at 60+. Johnston's

[60] book chapter on LGBT Aging and Elder Abuse also referred to older LGBT as persons aged 60 and more. The 60+ standard to include older LGB in research was also observed in the National Centre on Elder Abuse's [21] research brief. Further to this, Robson et al. [1] reported that participants in their project aimed to raise awareness and address elder abuse in the LGBT community in Vancouver were 60+ years old.

To support the idea of viewing older adults in the trans community as being in the 65+ age range, Teaster et al. [47] recognized that older adults in the US transgender/LGBT community are neglected, and these older adults are 65+, as does British Columbia's LGBTQ+ service provider Qmunity [61]. Furthermore, a community-based study on *Domestic Harm and Neglect Among Lesbian, Gay, and Bisexual Older Adults* in the US focused on recruiting LGB participants who are 60+ [27]. Witten et al. [62] recognized and described the 65+ age as the benchmark for describing older adults in the LGB community. Espinoza's [63] newspaper article on the housing challenges facing LGBT older people also defined the LGBT older adult population based on age 65+. Cohen and Murray [53] recognized the 65+ years classification for LGBT older adults. Butler's [52] study of the disclosure and discrimination problems among lesbians in Maine, USA utilized the 65+ cut-off age to identify older LGBT in the study. Similarly, in New Zealand, age 65 is the cut-off point for classifying older adults, and this age grade has been applied to LGB research [31]. The age 65 appears to be characterized by a low level of research participation in the GSM community.

4.1 Physical

Canada's Elder Abuse Ontario defines physical abuse among LGBT older adults as including injuries such as skin dehydration, lacerations, burns, bruises in unusual areas such as the chest, abdomen, face, or extremities, unexplained fractures or a history of "accidents" [42]. According to a Canadian study [28], physical abuse can potentially occur due to stressful situations such as COVID-19, and physical conflict and frequent family discord can be a precursor to abuse and neglect. A US study [27] revealed that up to 25% of caregivers perpetrate physical abuse, which is associated with the stress of providing care. However, stress is not the only reason for physical abuse of LGBT older adults. Another US study [64] showed that physical abuse occurs as a way of punishing LGBT individuals for their sexual orientation such as forcing a trans woman to live in the men's wing of a care facility [64]. In Caceres et al.'s [55] US study, encounters with staff of long-term care services accounted for 14 per cent of physical attacks on perceived transgender people. Members of staff are not alone in perpetrating physical attacks on LGBT seniors, a US study documented physical abuse perpetrated by co-residents in long-term care settings, including behaviors such as pushing, hitting, kicking, destroying property, or stealing [41].

An Australian study identified increased incidences of physical violence against gays and lesbians as a negative response to the legalization of same-sex marriage [36]. Other studies have identified transphobia as a motive for physical abuse and violent conduct, for instance for the general US population over 16 years the rate of violence against transgender persons was 2.5 times the rate for cisgender persons [23].

Reports from the US show that LGBT men experience physical attacks three times more often than women [21], and at least 43 per cent of transgender older individuals have been physically attacked [42]. In the UK context this abuse includes violence perpetrated by partners or ex-partners of LGBT older adults [48].

4.2 Psychological

Verbal abuse is a significant form of psychological abuse and the most common type among older adults, according to a Canadian study which found that it is associated with high levels of depression and anxiety [28]. In residential care, a US study established that verbal abuse is the most common type of mistreatment, and LGBT seniors are often subjected to disparaging remarks about their sexual orientation, such as the use of derogatory terms like "fag" which can have a profound emotional impact on them [41]. Another US study showed that LGBT seniors are likely to experience verbal abuse regarding their sexual orientation throughout their lives, often from intimate partners, close family members, and caregivers [27]. Verbal abuse can take many forms, such as silent treatment, insults, and intimidation. The fear of verbal abuse ranks second after neglect (67 percent) as the most feared form of abuse (60 percent) among LGBT older adults, according to an NCEA report in the US [21]. Similarly, Elder Abuse Ontario's report in Canada found that about 80 percent of the population has experienced verbal abuse [42].

Another form of psychological abuse that is specific to the wider 2SLGBTQIA+ population is the threat of 'outing' [65], using this perpetual threat to psychologically control another person. Another specific psychological abuse is keeping a person isolated from their 2SLGBTQIA+ community/resources which can result not only in loneliness but in a feeling of low self-esteem [65].

4.3 Financial

Financial abuse can be defined as including embezzlement, fraud, misuse, taking money under false pretenses, forced property transfers, forgery, or purchasing expensive items without the knowledge of the LGBT older adult [27]. Stealing and misusing an LGBT older adult's money are major forms of financial abuse, as is blackmail [27]. One US study reveals that home care providers blackmail LGBT older adults and tried to prevent their access to financial aid [45].

Financial abuse is one of the two most common forms of elder abuse (the other being psychological abuse) [46]. Gutman et al. (2023) [29] found that LGB in the CLSA reported financial abuse at 5.2 percent compared to 1.3 percent among heterosexuals. This increased susceptibility of LGB to financial exploitation may be due to the fact that 2SLGBTQIA+ relationships in the past had to make informal arrangements for finances due to a lack of recognition by banks and other institutions [34]. Further, as Cook-Daniels [66] posits, same sex couples may have put all their assets in one name to avoid questions of having two male/female names on a single account.

4.4 Sexual

Sexual abuse of older GSM adults is a serious issue that can cause physical and emotional trauma. Sexual abuse is defined as non-consensual sexual contact, including sexualized kissing, fondling, and forceful participation in conversations about sex against the victim's will [47]. Sexual abuse is often marked by trauma to the breasts and genital area and sexually transmitted diseases [47]. A US study found that 7 percent of participants had experienced sexual abuse but faced challenges and barriers to reporting that abuse [27].

4.5 Neglect

Neglect towards older GSM adults is defined as the intentional withholding of support, such as food, water, clothing, medication, personal hygiene, and assistance with activities of daily living. Self-neglect occurs when LGBT older adults live alone and do not seek medical care or eat properly [27]. Despite the high occurrence of neglect and self-neglect among older LGB individuals, they are rarely reported to authorities, with 62.8 percent of their respondents reporting experiencing instances of self-neglect [27]. Troublingly, in this study 22 percent of LGB older adults reported being neglected (and abused) by their caregiver whilst 25 percent reported that they knew someone who was being neglected [27].

An Australian study identified internalized homophobia as the root cause of neglect among LGB older adults [44]. Fear of discrimination often leaves older 2SLGBTQIA+ adults preferring not to access services [67], and fear of neglect is a significant factor in LGBT older adults' decision to hide their sexual orientation [35].

Support networks for older LGB people have a different composition than those for older heterosexual people containing more non-relatives [43]. This can create other barriers as LGB report significantly less contact with their support networks than do heterosexuals [68], and a history of family rejection [67]. This may result in lack of support in accessing services [43].

5. Systemic Discrimination in Service Provision

The Vancouver Foundation's study found that systemic discrimination against GSM older adults is deeply rooted in Canadian history which partially decriminalized homosexual acts in private for those over 21 in 1969. Likewise, the removal of the designation of homosexual behavior as a mental health disorder took until 1973 to be achieved, and the legalization of equal marriage occurred in Canada in 2003. It was only in 2000 that the Canadian pension system granted access to benefits for same-sex couples [24]. This systemic discrimination contributes to the invisibility and erasure of older GSM individuals, leading to limited access to resources including within the health care system, assisted living and residential care. Similarly, Webb and Elphick's [44] (2017) study in Australia confirms that older LGBTI+ individuals have been exposed to a lifetime of discrimination and, therefore, require legal services that are not biased but are empathetic to their needs. This study also revealed that older LGBTI+ individuals are often overlooked in the policy-making process due to the invisibility imposed by the system. This is especially problematic in the legal system because laws intended to protect older adults may have different effects on older GSM persons. This includes issues such as same-sex partners' legal rights, property ownership, wills, financial and personal affairs, end-of-life decisions, and advanced planning processes. Bloemen et al.'s [25] (2017) study in the US highlighted the challenge of accessing Medicaid for older LGBT adults. The support offered by Medicaid may not meet the daily needs of this population. Bristowe et al.'s [26] (2018) study found that older GSM adults prior experiences of disclosing identity included experiencing discrimination and even violence, as such formed a barrier for care interactions in later life.

Stein et al.'s [69] (2010) research in the US observed that anticipated discrimination, where LGBT older adults anticipate discrimination before entering the health system and, as such, delay their care-seeking, is another form of discrimination that occurs, this has been confirmed by Waling et al [36] in Australia and by Robson et al. [34]. in Canada. Florance and Hermant's [49] (2021) report on Australia confirmed that discrimination occurs legally and is mostly sanctioned by law.

5.1 Healthcare

Butler's US study observed that the LGBT community is implicitly diverse and consists of different population groups. This implies that each population group within the community has its own unique health concerns [52]. Waling et al.'s [36] (2019) study in Australia revealed the challenge of identifying specific health needs for lesbians and gays, as care workers were unable to recognize their care needs. A New Zealand study highlighted the fact that transgender LGBTQ+ older adults may face more hormonal health challenges compared to other populations in the LGBT community [56]. For example, Caceres et al.'s US study [55] reported a practice gap in which some mental health care providers in a long term services and support (LTSS) unit, have never cared for LGBT residents and felt unprepared to understand the distinctions in healthcare needs among different population groups in the LGBT community. In an example of advanced care planning, lesbian and bisexual women use multiple planning strategies, including a will and proxy, more than unmarried heterosexual women [55].

Robson et al. [34] (2023) found that knowledge of sexual and gender identity was believed to negatively impact services and even lead to mistreatment of a disabled older lesbian. Rosenblum [64] (2014) concludes that the USA healthcare system has a long history of LGBT abuse, including the use of electrocution in the 1930s. Whilst Robson et al. [34] (2023) remind us of the ways in which 2SLGBTQIA+ were negatively treated during the beginnings of the AIDS epidemic, still generates distrust of the healthcare system in Canada today. Furthermore, Walsh et al.'s study [60] suggested that marginalized older adults are not usually asked if they have experienced abuse, highlighting the need for social workers to be more alert to signs of abuse [60].

The preparedness of the health system to address the healthcare needs of LGBT seniors has been questioned. This is reflected in the Vancouver Foundation's (2014) findings in Canada, where research participants noted that the health system is ill-equipped in terms of policies, practices, and facilities to handle the specific needs of LGBTQ seniors [24]. A US study found that the rural-urban dichotomy regarding the availability of healthcare services is a major challenge for older LGBT adults living in rural communities [70]. Several studies [34, 38, 64] identify the need to respect the lifelong trauma of LGBT seniors as one of the specific needs that should be considered in healthcare decision-making about LGBT older adults. The healthcare system must also consider the trauma associated with living alone without family support, caregivers, and children, which occurs because of their sexual identity and the need to stay safe. For example, Bouchard et al. [70] (2021) report that LGBT older adults are at increased risk of chronic conditions and cognitive impairment, possibly due to a lifetime of trauma. A New Zealand study notes the disproportionately high poor health outcomes among LGBT seniors compared to heterosexual people, with a higher incidence of diseases like cardiovascular disease, diabetes, and HIV/AIDS [56].

Another area of concern for LGBT seniors' healthcare needs is the lack of establishment of community rules that promote respect and minimize hostility among healthcare workers and other users of health facilities towards their sexual identity [63]. Canadian research has also revealed that using homophobic pictures in staff rooms can further promote discrimination and disrespect against LGBT seniors [32]. Additionally, Willis et al.'s UK study [38] and Benbow and colleagues' [39] study of Australia, Canada, UK, and the US have highlighted the issue of "othering," whereby phrases like "not on this floor" are used to make LGB older adults "invisible" within the facility. Not surprisingly, rejection and insensitivity have also been reported [39].

Moreover, Butler's US report has noted that older lesbians constitute the most invisible group within the LGBT community due to multiple assumptions about their social status [52]. These assumptions include the conflation of heterosexist assumptions regarding sexual orientation, asexual assumptions about older women, the linking of these assumptions with gay men, and the consequent sexist assumptions about these issues.

Another major challenge within the US healthcare system is that the focus on the growing health needs of the older population overrides the needs of LGBT seniors [45]. Vancouver Foundation's report in Canada also highlights the lack of success in LGBTQ competency or cultural diversity training within the healthcare system [24]. Similarly, Kortes-Miller's Canada study has reported that Canada has not been able to meet the needs of LGBTQ+ individuals [30].

Benbow et al.'s narrative review in the UK described the prevalent concerns and fears of discrimination against trans individuals [39]. Health decision-making often requires the disclosure of sexual identity, which can lead to discrimination throughout the continuum of care. Discrimination can manifest in various ways, such as insensitivity, outright refusal of care, denial of agency, and gatekeeping. Discrimination from service providers can lead to reluctance to access services and their ability to be open and honest with healthcare practitioners. Internalized stigma can also compound these concerns. Ultimately, discriminatory practices create a major problem of trust in the health system.

A Canadian study observed the preponderance of the 'Double Wammy' or 'Double disadvantage,' where the challenge of being an LGBTQ older adult is intertwined with the problem of intersectionality - and multiple social positions [30].

5.2 Long Term and Home Care

Westwood's study [37] in the UK reasoned that heteronormativity reflects both a linguistic and cultural performance of marginalizing and making non-heterosexual relations 'invisible'. Such a situation can lead to stressful situations within long term care (LTC) where LGBTQ older adults must return to their original sex definition (return to the closet) to become socially acceptable [30]. A US study confirms that organizational change aimed at developing a community culture that recognizes and supports diversity is an effective way of helping long-term care residents become more respectful of varying sexual perspectives [41]. Some LGBT older adults also racially profile caregivers and support workers from other ethnic minorities as being culturally averse to working with LGBT individuals [52].

In 2010, Walsh et al. [60] found that homophobia is perpetuated when other users isolate or distance themselves from the LGBT older adult within the facility and it appears that the literature shows that such homophobic and transphobic attitudes remain even if they cannot be proven [34]. In LTC facilities in the US, microaggressions against LGBT older adults have been reported. For instance, bringing a Bible to help an LGBT older adult pray and ask for forgiveness or to be "cured" has been identified as a form of microaggression [64]. In the delivery of home-care services, Butler's research in the US has provided evidence of microaggression, such as the lack of eye contact between a lesbian older adult and a female care worker, leaving behind religious material after home visits, and false and outrageous records about LGBT seniors [52]. Robson et al. [34] (2023) also found instances of clients being told by care givers of special trips to mock 2SLGBTQIA+ folks

and of false accusations being made against the client for merely asking the care giver to provide care to an older lesbian.

Research conducted in New Zealand by Neville and colleagues [31] (2014) revealed that care workers who express non-accepting views of LGB among their family members, friends, or colleagues potentially reflect these attitudes in their care of LGB older adults. Caceres et al. [55] (2020) review of US studies found that negative attitudes toward LGBT seniors are due to a lack of LGBT health training. Similarly, Neville et al. [31] (2014) found that training gaps exist within formal care settings, and care workers require culturally appropriate formal training to potentially reduce microaggressions. In the US and Canada, there is an acute lack of awareness and training for staff, and LTCs in Canada have recently started adopting LGBT inclusivity training [35].

In Westwood's research [37] in the UK, she writes that issues regarding long-term care are more likely to affect older bisexual women than older bisexual men because women live longer than men and are more likely to spend their final years in residential home-care spaces for older people. Bisexual participants in focus groups expressed real fears about their future as they had very little confidence that home care workers would be trained and supported to provide a sensitive service, free from prejudice [50].

Older LGBT women may be more likely to want gender-specific provisions than older GBT men. The majority of women in Westwood's study (62%) expressed mostly wanting either women-only or lesbian-only accommodation, with many of those who chose lesbian-only as their first option, selecting women-only as their second option [37]. The least popular option among the women participants was mixed gender LG, LGB or LGBT provision. The majority of gay men in the sample, by contrast, expressed a first preference for mixed mainstream provision, and a second preference for gay men-only accommodation [37]. Willis et al.'s study [38] (2016) also supports Westwood's research, showing that some women indicated their preference for living in gender-specific care facilities. A participant in their study said, "My ideal in terms of care would be to be in a sort of sheltered accommodation that was just for lesbians because I wouldn't particularly want men around, to be honest, gay men or straight men" [38].

6. Microaggressions

Microaggressions have already been briefly mentioned, but it is worth exploring further. Microaggression is a prevalent form of abuse against individuals in the GSM community. It involves subtle and indirect discriminatory behaviors, attitudes, and experiences that express biases against older adults who have disclosed their sexual orientation or identity. These behaviors occur at the micro-level of interaction through one-on-one social exchanges, such as harassment, slurs, and institutional imbalances. In a US study, microaggression was found to be a type of bullying that frequently occurs and negatively affects well-being [41]. Additionally, Westwood's UK study contextualized discrimination among older LGBTQ individuals as a lifelong experience that co-occurs with disclosing their sexualities [50].

In homosexual relationships, dimensions of microaggression manifested as homophobia, biphobia, transphobia, and heterosexism have been identified. A US study revealed that microaggression occurs in homosexual relationships when they live in societies that do not fully support the rights of sexual minorities [27]. In the home setting, research in Canada established that

homophobic family members prohibit LGBT partners from visiting [60]. Robson et al. [34] report respondents experiencing what they felt was homophobia without it being overt, yet still harmful.

Microaggressions also have a racial dimension among LGBT individuals. Research in the UK established that LGBT people of colour face additional challenges [56], and a study in Canada identified the risk of discrimination, marginalization, and abuse among First Nations persons [30]. In addition, a US study revealed that multiracial LGBT older adults experience disproportionate levels of depression compared to the white cohort [40] which may be attributable to experiencing microaggressions on several aspects of their identity.

Because of the trauma experienced by GSM seniors due to discrimination, it is recommended that all social and health service agencies use a trauma informed approach (TIA). TIA approach recognizes and responds to the impacts of trauma on an individual's life. Service providers learn how to communicate, build trust and provide compassionate care in collaboration with those who have suffered trauma in order to create a healing environment.

7. Other Factors Creating Vulnerability

Elder abuse of all forms is experienced by older GSM people. In many ways this resembles what is experienced by their heterosexual counterparts but is also rather different [34]. In this section we discuss some of those differences.

7.1 Isolation

It is known that GSM elders are more at risk than their heterosexual peers for abuse and part of this is the increased vulnerabilities that come with isolation. As far back as 2011, the literature [71] indicated that over 50 percent of LGB older adults reported feeling isolated with the figure even higher for trans people. This latter fact may be explained by the historical practice of doctors and other practitioners advising trans people to divorce their spouses and move to another region to begin life again in their new identity [20].

Living in isolation within the residential care setting is one of the biggest fears for LGBT older adults, as only one long-term care facility in two health authorities in Canada (Vancouver Coastal Health Authority and Fraser Health Authority) openly support trans and queer living environments [24]. A New Zealand study found that the lack of attention to the specific needs of non-heterosexual seniors, combined with being different from most other residents, can lead to isolation. Heteronormativity is also a challenge for gay men, as they are often considered "perverts" or "sexual predators," which can lead to isolation [31].

Geographic isolation is another cause of isolation among older LGBT individuals [45, 70]. Older LGBT individuals living in rural communities often lack necessary social support and transportation, and they may also experience isolation due to the loss of a partner [45, 70]. Race and ethnicity are also factors that contribute to the experience of isolation among older LGB adults, as the complexities of identity and attendant inequalities can promote isolation [37].

When older LGBT individuals enter residential care, they often feel disconnected and isolated from the support structure provided by the LGBT community in the outside world. LGB seniors are concerned that entering into a residential facility may isolate them from their existing social networks, as noted in Skeldon and Jenkins' review of studies in Australia, Canada, New Zealand, United Kingdom, and the US [56]. Late-life bullying is also a predictor of self-isolation among LGBT

older adults, as the fear of escalated violence occurring because of yelling and other disruptions within the facility are practical considerations for self-isolation among LGBT seniors [41].

Isolation also prevents the reporting of abuse as isolated LGBT older adults are vulnerable and face barriers in reporting abuses [46]. Webb and Elphick's [44] (2017) study in Australia also revealed that the feeling of isolation extends to the inability of LGB seniors to find legal representation. Waling et al.'s [36] (2019) study in Australia identified how mobility-related disability among LGBT older adults who live at home could cause isolation, as they may be unable to access certain services or events.

7.2 Culture

Teaster et al.'s [47] (2014) study, conducted in the United States, highlights that culture plays a significant role in defining, interpreting, and reporting elder abuse, and in understanding how different generations understand it. Although elder abuse is prevalent among older adults in different cultural groups, LGBT elders face disproportionate abuse due to their sexual orientation. For example, Reygan and Henderson's [33] (2019) study in South Africa showed that the dominant patriarchal nature of the country creates gender constructs that do not include LGBT persons. For example, regardless of sexual identity, a man is addressed as a man, emphasizing the importance of respect in the culture. Conversely, Haskell's [45] (2015) report from the US presented an example of acceptance, showing that US culture has become more accepting, which has positive implications for the future generation of older GSM individuals to find support and community.

Witten et al.'s [62] (2014) US collection highlights that the cultural system embodies the functioning of other aspects of society, such as policies, programs, and institutions. A New Zealand study [31] suggests the existence of an inside culture called the 'homosexual culture.' This study showed that the overarching unsupportive cultural system for LGB individuals contributes to the lack of a culturally safe environment for LGB individuals using health services, including residential care, despite cultural competency being a regulated competency within the nursing profession [31]. Gutman et al.'s [2] (2020) Canadian study argued that the LGBT community also lacks a strong culture of supporting LGBT older adults, as the LGBT movement has predominantly been ageist and disproportionately focused on younger people.

7.3 Cultural Safety and Humility Training

A one-size service for GSM populations does not work and practitioners need to be trained in cultural safety and humility to work with GSM people [65]. The term cultural safety originally was created to address the discrimination faced by Indigenous peoples but it can be broadly used to create a trusting and equal relationship within healthcare and provide a person-centred approach, where the practitioner does not make assumptions but is open and learns from the person and provides care based on the particular knowledge of the person without causing harm. This training needs to be regular and repeated training as the majority of staff in long term or home care are in precarious employments with regular turnover of staffing [34]. A lack of cultural safety and humility training leads to unsafe environments, such as discrimination and abuse against GSM seniors in the legal, health, and housing sectors. Within the health sector, practitioners, including health care staff and physicians, play a crucial role in shaping the experiences of GSM seniors. Unfortunately, despite

this need being identified as early as 2010 [69] and cultural safety and humility being adopted as a competency for health professionals, training offered has not always resulted in safe environments.

There is a current lack of knowledge among social and healthcare workers in providing culturally safe care to the GSM seniors population. This lack of knowledge and limited evidence will undermine optimal care delivery and permit housing and health disparities in this important and vulnerable population [32]. Evidence suggests that older LGBTQ+ adults have unique needs at the end of life that require social and healthcare workers to receive further training on how to create safe spaces so LGBT residents do not fear disclosure or experience discomfort in care homes [35, 56].

A primary recommendation to create a supportive environment for GSM seniors is through training for practitioners. However, Caceres et al.'s [55] (2020) study in the US raises an important observation about the role of sociocultural diversity, making it difficult to develop comprehensive guidelines. Webb and Elphick's [44] (2017) study in Australia also reported that staff members mostly come from culturally diverse regions with different interpretations of same-sex relationships and dimensions of homophobia. This highlights the challenge of designing culturally appropriate responses for practitioners. That being said, Sussman et al.'s [35] (2018) study in Canada observed a gradual attitudinal change among staff members. That report indicated that staff are gradually becoming more open to LGBT-services initiatives, which was achieved through partnerships, collaborations, and the use of toolkits. Therefore, it is important to recognize that the desired change is not solely a result of training but also a combination of various activities implemented over time.

Research conducted in New Zealand by Neville et al. [31] (2015) revealed that care workers who express non-accepting views of LGB among their family members, friends, or colleagues potentially reflect these in their care of LGB older adults. Caceres et al.'s [55] (2020) review of US studies found that negative attitudes toward LGBT seniors are due to a lack of LGBT health training. Similarly, Neville et al. [31] (2015) found that training gaps exist within formal care settings, and care workers require culturally appropriate formal training to potentially reduce microaggressions. In the US and Canada, there is an acute lack of awareness and training for staff, and LTCs in Canada have recently started adopting LGBT inclusivity training [35].

In Canada, the Vancouver Foundation (2014) reported limited staff training on LGBTQ competence and highlighted the necessity for training programs and internal policies to drive the desired change [24]. Such training should include guidance on how to ask questions about sexual orientation when administering the Residential Assessment and Intake (InterRAI) instrument and Robson et al. [34] (2023) recommend that all intake protocols should allow for the potential for a client to disclose sexuality/gender identity safely.

Caceres et al.'s [55] (2020) study in the US also observed that mental healthcare providers in long-term support and services struggle to distinguish the healthcare needs of different population groups within the LGBT community. This further emphasizes the importance of improved training and understanding among mental healthcare providers.

Butler's [52] (2017) US study has revealed that staff training in long-term, residential, and home-based care settings has not resulted in significant changes in the quality of care, as most training programs are narrow and focused on professionals. A significant factor contributing to this issue is the specific missing components in the training of care staff. Willis et al.'s [38] (2006) UK study has found that LGB identities and history were absent from the staff training curriculum, leading to limited knowledge of sexual identity and symbols and reluctance to say words like

gay/lesbian/bisexual aloud. In extending the discussion about training, while Willis et al.'s [38] (2006) UK study supports the inclusion of LGB identities and history training in the healthcare staff training framework, it was noted that having an exclusive "how-to-work-with-LGB" approach could potentially promote social divisions.

Regarding the privacy and autonomy of LGBT residents, Webb and Elphick's [44] (2017) study in Australia discussed whether the decisions of same-sex partners are genuinely valued or considered in healthcare decision-making. Additionally, when it comes to autonomy in decision-making during illness, it becomes challenging to determine whether the same-sex partner or an "estranged" family member of the LGBT senior will make healthcare decisions.

To ensure lasting change, multilevel training involving both staff and management should be ongoing rather than one-off. This approach promotes awareness, inclusivity, and openness across all levels of care. Supporting this position, a review conducted by Benbow and colleagues across studies conducted in Australia, Canada, the UK, and the US demonstrated that training across all levels, combined with an infusion of positive practices knowledge, will provide the required change [39].

8. Conclusions

From this scoping review we are able to make several conclusions that can assist the development of policy and practice both in terms of future research and in service provision. These include the observations and conclusions of authors in this review.

8.1 Research

8.1.1 Recommendation 1

There is a need for further research, both qualitative and quantitative that acknowledges the power of historical experiences that may still influence people. More is needed about how best to provide person-centred care [39]. Although GSM people have many shared lived experiences, they also have unique life histories which require more research to develop information and interventions to support their later-life care and prevent abuse [30, 39]. It is imperative for future research to consider the socioeconomic inequities faced by racialized GSM elders [39, 40]. In particular, we conclude:

8.1.2 Recommendation 2

There is a great need to fund both quantitative and qualitative data collection and analysis on GSM elder abuse. This is based on the fact that we found only 16 records from the past decade that collected and reported on primary data [25-38].

8.1.3 Recommendation 3

The literature highlights particular physical healthcare issues and the need to acknowledge the power of historical experiences that may still influence people many years later. It raises questions and calls for more research about how best to provide person-centred health and social care for gender-diverse elders [39]. Although LGBT people have many shared lived experiences, they also

have unique life histories which require more research to develop information and interventions to support their later-life care and prevent abuse. Such research needs to acknowledge and focus on the nuanced and unique health concerns of gender-diverse elders [30, 39]. This work to collect lived-experience narratives has begun [34].

8.1.4 Recommendation 4

Like most Gerontological literature there is little from low- and medium-income countries and most of the extant literature is Anglo-centric (as reflected in this KS). As such, certain groups such as racialized people [39] are under-represented, as are those experiences and voices from the Global South.

8.1.5 Recommendation 5

There is a need for research that includes GSM older adults as research partners, including on grant applications, research design; analysis is recommended etc. [41]; for studies that focus on hard-to-find voices [34, 43].

8.2 Practice

8.2.1 Recommendation 1

From the papers and studies aggregated here we conclude that trauma-informed and culturally safe training is required for all levels of practitioners. This training needs to be frequent and available to the precariously employed care-aides who are often low-paid and have a high turnover [34].

8.2.2 Recommendation 2

Practitioners should have a zero-tolerance policy for homophobic and transphobic statements, names, behaviours; with a clearly accessible and safe reporting mechanism.

8.2.3 Recommendation 3

GSM folks are often invisible, whilst displays of rainbows etc. indicate a certain awareness, LTC should also include 2SLGBTQIA+ speakers in their programming and provide 2SLGBTQIA+ materials/resources such as magazines, books, movies.

8.2.4 Recommendation 4

There is a need to develop GSM competent services for the disclosure of elder abuse [34].

8.3 Policy

Primarily there is a need to develop policies that will change practice, in particular, we stress the following:

8.3.1 Recommendation 1

Those working with elders need to be aware of the possibility that clients might identify as GSM and might be reluctant to share their identifications. Staff should not assume heterosexuality. Intake forms should always include 2SLGBTQIA+ identification options [34].

8.3.2 Recommendation 2

GSM competent training and cultural safety training are essential. Particular attention should be given to residential and in-home care aides, who are often low paid and lack nuanced awareness of GSM issues and rights [34]. Training should be ongoing, rather than discrete and annual. It should include attempts to provide 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 trans clients [34]. The intersectionality of GSM and race places the person at greater risk [30, 34, 56]. Training of staff is needed to help create trust and equal power relations with elders. The staff need to get to know the unique individual in front of them instead of making assumptions based on physical appearances which may lead to discrimination.

It appears that what we knew back in the 2010s has not been refuted, but rather reinforced, by newer research. Whilst much of the elder abuse experienced by GSM people resembles the experiences of their heterosexual peers it has been shown that there are also differences [34], including growing up in an historically hostile time resulting in systemic cultural violence. GSM elders also have a distrust and suspicion of health care providers and medical systems partially due to memories of how GSM people were treated during the AIDS epidemic. Further, the existence of overt, covert, internalized homophobia and transphobia does not affect non-GSM people in the ways they impinge and affect the lives of GSM older persons. Nor do cis/heterosexual persons face the experience of invisibility of their identity when systems and services assume cis gender and/or heterosexuality [34]. As such, our final conclusion is that we need to remain aware of the specific vulnerabilities of GSM older adults.

Author Contributions

Marchbank was the lead on this project in management and project write up. Reed supervised the database searches and authored the methods section. Gurm, Gutman & Robson assisted with writing text, editing and proof reading. Marchbank, Robson, Gutman and Gurm collaborated on recommendations.

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Competing Interests

The authors have declared that no competing interests exist.

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