FROM ISOLATION TO INCLUSION

Reaching and Serving LGBT Seniors

housing, services, and community for LGBT seniors

openhouse

LGBT Aging Cultural Humility Training

ONLINE MODULE TRAINER PACKET

INTRODUCTION

As service providers, we want our clients to feel safe to share their concern needs and histories. We must learn to create spaces that invite our clients to share their personal backgrounds including their experiences of oppression Through stories and scenarios, this module will help you develop best practices for working with your LGBT senior clients. We'll review historical events and terminology, and get you ready for the face to face training offered after this module. There, you will have time to ask more in-depth questions, speak with other service providers, learn about resources available for your clients, and practice what you've learned.

Cultural Humility & LGBT Seniors

Key Content
LGBT seniors often face sub-standard care within health and social services, whether due to overt discrimination from providers or unintentional barriers that prevent LGBT elders from feeling welcome. For LGBT seniors, the experience of exclusion is amplified by being the targets of both ageism and homophobia. In this section, we will hear about the impact of Common Assumptions made by providers that unintentionally further isolate LGBT seniors. We hope this will provide a context for why this training is important.

LGBT Senior Vignette 1: *Xavier*
Hi, my name is Xavier, and I was born in 1950. My life has been filled with adventure, love, and, tragedy. Where I was born, what I liked and who I liked, well, that was not ok. I decided to escape as soon as I could, and moved to New York City in 1970, right after Stonewall. It was a great time to be in the city, and there were handsome guys all around. I made lots of friends, and it became my home. But that only lasted so long. About 10 years after I moved there, my friends started getting sick, and even dying. AIDS had come to New York, and it was so bad. So many people died. I lost a friend almost every week for about five years – until there was almost no one left. It was lonely and scary. But, I got through it, found more people who were in the same situation as me, and created a life for myself. I moved out to the Bay Area about 20 years ago, and found another community. Everyone here had similar experiences – losing friends and lovers, and having to rebuild. I mean, at least I never got sick.

About a year ago, I started feeling really tired and worn out. It was like I had the flu – but not bad, just all the time. And I wasn't hungry either, and started losing weight. My friends started to get worried. Finally, I went to the clinic. They had me fill out some paperwork, but none of it really applied to me. I have never been married, and they never asked if I had a partner.

The people in the clinic just didn't seem to care much about me or my experiences. They asked me about my physical body, but never asked about my life history, who my supports were, or who I actually was. They seemed to think that they knew everything that they needed to know about me. When in fact, they didn't really know anything at all! I wasn't going to just talk to them about my personal life if they didn't even care enough to ask.

At first, they told me that this was just what it was like to get old – but I am not that old! I really thought they were wrong, but I didn't know how to say it. I finally just came out and said that I was a gay man, and that I was worried that I might have something more than just "old age". Even though I was upset, it didn't seem to matter. The minute that they figured out I was gay, then it could only be one thing – HIV. I hadn't had a test in a while, but that didn't mean that they should assume that they know me and my business.

They eventually gave me an HIV test, and it was positive. That was hard. All I could think about was the people that I had lost, and that I was going to go that way as well. I have never felt so scared or alone in my life.

Key Content

Xavier's experience with his healthcare providers is all too common. Service providers may believe that by not asking about sexual orientation and gender identity, they will prevent discrimination against LGBT individuals. Perhaps Xavier's providers were uncomfortable asking these questions of Xavier's as a Latino elder. They perceived him as heterosexual, because he didn't "look gay." What might be a better way to approach Xavier in this situation?

Xavier's healthcare providers didn't ask him about his history and therefore missed an opportunity to build trust and safety for him to disclose his own concerns about his health. Providers may buy-in to the stereotype that portrays LGBT people exclusively in terms of their sexual behaviors. For LGBT seniors, this assumption may be amplified by being both the targets of ageism and, heterosexism. Because our culture tends to desexualize older adults, providers failed to see Xavier as sexually active. Providers then assumed if Xavier was not sexually active, how could he be LGBT? As providers we must internalize that

being LGBT is about far more than who a client is having sex with. Have you ever heard someone say, "I don't need to know what they do in the bedroom, so why does it matter if a senior is LGBT?"

Key Content

As service providers, it is important that we view of our clients rom a holistic perspective – seeing them as individuals who have different facets of their identities and different lived experiences. In order to give our community members the most effective care, we need to learn about them, through their eyes.

LGBT Senior Vignette 2: *Robert*

Well, hello there! I'm Robert. I have long felt that I was born at the crossroads of history, both as an African American man and as a same gender loving (gay) man of color. I was born in the Spring of 1949 in Chicago to parents who were part of the second large migration of African Americans to northern and mid-western cities during the midpoint of the 20th century. Finally, at 67-years old I feel that now I am able to live my life the way I was meant to.

All these years, I've done what I was "supposed" to do. I married my high school sweetheart, Leslie, had kids, the whole bit. But this entire time, I have been untrue to myself. Shortly after Leslie and I started dating seriously, I met a guy through my cousin. Montel and I hit it off instantly and became fast buddies. Soon we were inseparable and everyone started to notice, even Leslie. I cared for her, but for some odd reason it was just different—it is hard to explain—with Montel it was a deeper connection, like I had never felt before with a girl (or woman). This went on for about six months when Leslie confronted me about Montel. I denied her probing and things seemed to settle down.

In 1967, I decided that it would be better if Montel and I left Chicago for San Francisco where he and I could start our lives over again as lovers and be done with Chicago and its Midwest small-town attitudes. He liked the idea but when he told his mom about our plans, she replied, "if you leave this house to go to San Francisco with Robert, never come back to this house again!"

We were both crushed and devastated, for I knew in my heart of hearts he would not leave his beloved mother. So, I asked Leslie to marry me and I went on to live the lie that so many of my generation lived. We moved to San Francisco and still, I never forgot about Montel, my first true love.

It's been two years now, since Leslie passed away. Now that I have lived alone for a while, I've opened myself to find true love of another man, Felix. My kids still live nearby and between them and my church family, I have a lot of support. I get pestered a bit by women at church about getting married again, but they mostly leave me alone. So do my kids – I guess they think that an old guy like me might not be interested in being with someone else at my age. Well, nothing could be further from the truth!

Lately, it has gotten harder for Felix and I to spend time together. I had a stroke about six months ago, and now my kids and my church family are here all the time, mostly because I need a lot of help to stay in my house. I don't want to move because I've lived here for almost 50 years.

The real problem is that my kids and my church family really don't like Felix and "his kind". Felix calls himself gay, and the people from church especially don't like that. I know that if they knew that Felix was my lover, they reject me. They say that being gay is a sin, and that Felix is wrong for living the way he does. I don't know how I would be able to stay in my house without their support – or the support of my children.

Key Content

Robert's providers knew part of his story, that he was a widower with three adult children and less active in his church community due to a stroke. These circumstances may have lead providers to assume Robert identified as straight. Far too often, people think you can tell who is gay just by looking at them. Providers may believe it is possible to accurately identify who is LGBT without asking. In Robert's case he had kept his true self hidden, until later in life.

Robert described himself as living at the crossroads of history, both as an African American man and as a same gender loving (gay) man of color. He also came out later in life. He said his kids assumed that

he no longer experienced desire because of his age. Unfortunately, providers too, may be influenced by ageist attitudes that tend to simplify or "flatten" our diverse identities and further add to the invisibility experienced by LGBT seniors.

Person-centered care requires acknowledging and valuing the many differences that emerge when providers are willing to factor in the complex intersection of age with other variables on identity.

LGBT Senior Vignette 3: *Adela*

Transgender seniors may face additional challenges than their cisgender peers. Let's hear about from one transgender senior.

My name is Adela, and I am a proud transgender Cuban American woman. I was born in Miami in 1940, the youngest of 5 children and, at the time, my parents called me Neo, which means "new life." Little did they know that my name would determine my destiny. I've always known that I was more like my sisters than my brothers. My mother was very loving, supportive and protective of me which allowed me to be who I was meant to be. I've taken hormones for many years and most people I have met know me as Adela. I haven't told many people about my past. I remember hearing stories from friends who came from Cuba about how they put all the lesbians and gays in camps – I don't want to know what they might have done with me!

I've lived in California for many years now and I've always spoken English, along with Spanish, bone one of the first things people ask is if I speak English. And how I like living in this country. Recently noticed that I am having a lot of trouble with my hands and joints. I have rheumatoid arthritis, and some days it is hard to even move around. Right now, I have friends that help me, but they are getting older too—I want to be around people who understand me and see me as normal. What are we going to do when we are too old to help each other? I like living on my own – I don't want to move into one of those places that is full of nosey old people. Sometimes, those places, are nice from the outside, but the people who live there are just awful. I know a lesbian couple who live in one and they tell me they are so lonely, they sit on their own at meals and the others shun them, as though they are lepers. What if they mistake me for the cleaning lady instead of a resident?

I mostly keep information about myself private – but what am I going to do if I can't anymore? I feel that I'm going to have trouble answering questions with the "truth". What if people tell me I can't be myself? Or that I have to share a room with a man because of my body parts? I'm terrified about what will happen to me in one of those places.

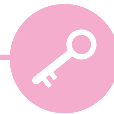
Key Content

Some LGBT seniors who have been out most of their lives go back into the closet when they get older or have to move into long- term care. For Adela and other transgender elders, the trauma and discrimination they've faced or witnessed lead to survival strategies involving hiding their identity due to severe distrust of health and social service institutions. **Providers may communicate using assumptions that we have "caught" or were "taught" about age, gender identity, and sexuality.**

Earlier in Robert's story, we discussed how providers may believe it is possible to accurately identify who is LGBT without asking. One of the first ways to convey safety and respect for transgender people is by consistently asking the preferred gender pronoun of all clients. While Adela is known to others as female, often times, providers make split-second judgments based on physical appearance and may be afraid to ask about correct pronouns, and thereby misgendering transgender individuals.

BACKGROUND TO KEY CONTENT

We listened to examples of unintentional barriers that prevent LGBT elders from feeling welcome and safe in Xavier, Adela and Robert's stories. They include the following:



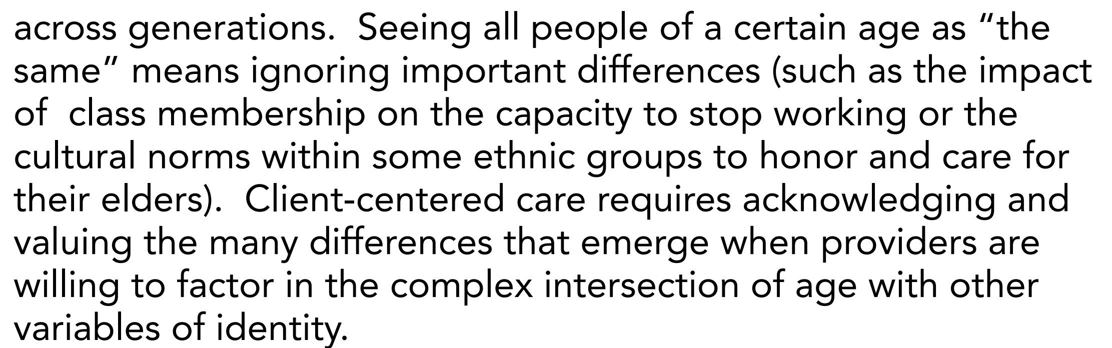
As health and social service providers, what do we need to consider so that we do not perpetuate the historical invisibility and exclusion of LGBT people? How do we deepen our awareness that, when we are not a member of the LGBT or aging communities, we may relate to our clients from a position of unconscious privilege? (This creates barriers to building respectful relationships and interferes with the effective delivery of our services.) Without this awareness, organizations working with LGBT elders are less likely to have thought about or understood the ways that their policies and practices may unintentionally have a negative impact on LGBT aging adults.

1) **Service providers may assume it is possible to accurately identify who is LGBT without asking.** We will explore and suggest methods for providers to ask elders about their gender identity and sexual orientation, to understand how they see themselves and how they want to be seen.

2) **Providers may believe that by not asking about sexual orientation or gender identity, they will prevent discrimination against LGBT individuals.** "I provide the same quality care for everyone." (Think for a moment about how this is a parallel to the strategy of "color-blindness", which encourages us to not see racial differences so that we don't relate to someone exposing our prejudices. In reality, while the intention may be to treat everyone "more equally", the impact of "blindness" is that we are less able to make authentic connections; we can't fully "see" that person of color without seeing their race which has shaped their identity and life experience.) Research shows that when we try to deny our differences, we actually are more susceptible to making assumptions (based on stereotypes) and judgments (bias). This gets in the way of building respectful relationships that includes seeing our differences.

3) **Providers may "buy in" to the stereotype that portrays LGBT people exclusively in terms of their sexual behaviors.** Because our culture desexualizes older people, providers may minimize the multifaceted significance of LGBT identity for seniors. (***ASK:* Have you ever said or heard someone say, "I don't need to know what they do in the bedroom, so why does it matter if a senior is LGBT?")** We will expand the knowledge about LGBT history and experience so that providers can relate to the depth and importance of affiliation with the LGBT community that goes far beyond sexual behaviors.

4) **Providers may be influenced by ageist attitudes that tend to simplify or "flatten" our diverse identities and further add to the invisibility experienced by LGBT seniors.** There can be assumptions that because people will want to hide or deny their age, it is better to group "old people" without making distinctions about age. ("She looks so good for her age.") In reality, there may be more differences within an age range or cohort based on multiple aspects of their identity than for people



across generations. Seeing all people of a certain age as "the same" means ignoring important differences (such as the impact of class membership on the capacity to stop working or the cultural norms within some ethnic groups to honor and care for their elders). Client-centered care requires acknowledging and valuing the many differences that emerge when providers are willing to factor in the complex intersection of age with other variables of identity.

5) **Providers may communicate using assumptions that we have "caught" or were "taught" about age, gender identity, and sexuality.** Have you ever used language (such as calling all women, "ladies," assuming that all women like the term? Or offered services based on traditional gender traits. "Let's take the guys to the ball game, and the "ladies" to the ballet," assuming males will like sports, females like the arts? These assumptions can trigger painful experiences for LGBT seniors who have lifetimes of feeling unseen or unaccepted for their differences around traditional gender scripts. This is particularly acute with transgender seniors. Using the incorrect pronoun or misgendering an individual can trigger negative behaviors. As we all learn to notice our assumptions and change our language, we are more likely to increase the sense of understanding and inclusion for all members of our service communities.

The invitation is for each participant to become aware of their assumptions, and to engage in personal learning in order to reduce the level of discomfort and avoidance that would perpetuate patterns of exclusion and invisibility.

Cultural Humility VS. Cultural Competency

What is the difference between cultural humility and cultural competence?

Key Content
Cultural humility sees individuals and communities that have historically been oppressed as experts in their own experience and therefore as an indispensable source of information about how to best serve them. It emphasizes active listening, seeking out the inherent wisdom in their lived experience to determine the best course of action.

Cultural competence assumes that by learning about other cultures, one can determine how to appropriately engage people of that group. It is static, and less flexible than cultural humility. It presumes that persons of a certain cultural act in a certain way, and that they don't change.

Trainer Notes: Cultural humility is a process, culture competency assumes mastery. The first step toward developing cultural humility is to build your knowledge base about issues that may be new or unfamiliar to you. In this section, we will establish common language and appropriate terminology for creating inclusion of older LGBT adults. Even if you are familiar with some or all of this information, try to think about it anew within the context of developing your own cultural humility. How can language play a role in our ability to see and treat people with greater cultural sensitivity, respect and dignity?

As American society has become increasingly diverse, some housing, health and social service providers have recognized the value of reaching out to and serving clients of all backgrounds in a culturally sensitive way. For many years, training and education efforts emphasized attaining competence in any number of cultural backgrounds as the model for realizing such sensitivity. While these goals were worthy, on a practical level, the expectation of achieving cultural competence is, at best, impractical. At worst, it reduces

the idea of culture to an interchangeable set of characteristics that allegedly defines whole groups of people without recognizing their unique individuality. In reality, it is not possible to predict the beliefs and behaviors of a person based on his or her race, religion, ethnicity, gender identity, sexual orientation, physical ability or national origin.

Rather than memorizing and responding to lists of alleged cultural traits, providers learn to approach each client with humility, listening actively for similarities and differences between their own perspectives and those of their clients, and communicating effectively to negotiate between the two. Being culturally humble means the provider must be willing to develop self-awareness and a respectful attitude toward diverse points of view.

No matter where your organization sits along the spectrum of cultural inclusion, it can always become more culturally respectful. Cultural humility emphasizes having institutional commitment throughout the agency, in areas such as hiring practices, composition of staff, and building partnerships with other members of the community. First and foremost, however, being a culturally humble organization requires a commitment from every staff member to continue learning from those who access your services so that you may better reach out to and serve all clients who might benefit from your work.

Key Content
Establishing a Common Language

A clearer understanding of terminology used to describe LGBT people can help us to explore deeper issues of inclusion and exclusion. Terms are crucial because finding out what terms the person uses and then using their language is a primary way of conveying respect and openness. Participants were asked to test their understanding by hovering over each term.

TERMS:

- Ageism
- Heterosexism
- Homophobia
- Biphobia
- Transphobia
- LGBT
- Gay
- Lesbian
- Bisexual
- Transgender
- Cisgender
- Sexual Orientation
- Gender Identity
- Gender Role
- Gender Expression

Additional Key Content in this section:

Ageism is exclusion and/or discrimination against people because of their age. It reflects a belief that "old" is less attractive, less important, less useful, and less worthy of attention and resources. Ageism is one way that LGBT older adults may be excluded by service providers within their own community. The signs of not belonging or being devalued can be subtle, and they are often invisible to people who do "belong" by virtue of being younger.

Homophobia is the historical term for prejudice based on fear, against lesbians and gay men. (Biphobia and transphobia also speak to the fear and hatred of bisexual and transgender people.) Heterosexism is a broader term to describe the privileging of opposite sex sexuality and relationships and the expression of negative attitudes, bias and discrimination toward the LGBT community. It can include the presumption that everyone is heterosexual or that opposite sex attractions are normal and "superior".

Trainer notes:
Review Glossary of Terms for additional key content and background in this section.

Statistics on LGBT Aging

Key Content
Have you thought about these issues for your LGBT clients?

Many social service providers have not, because they tend to minimize the presence of LGBT older adults in their case loads, especially if they are working in settings where LGBT clients are not comfortable sharing that aspect of their identity. Let's look at some broad statistics that reveal the presence of this population (even if they seem invisible).

- San Francisco is home to 20, 000 LGBT seniors age 60+.
- LGBT seniors are 5x less likely to access health and social services, many of which are offered through their local senior center.
- 50% of people living with HIV/AIDS are over 50 years of age. Long-term survivors are at particular risk of cardiovascular disease, stress-related illness, and mental health challenges.

Trainer Notes:
SAN FRANCISCO-SPECIFIC DATA THAT IS OPTIONAL
(Depending on Audience and Time) TO SHARE:

The scope of the unmet needs and health disparities among this population were identified in a community survey conducted for the San Francisco LGBT Aging Policy Task Force (2013). The survey revealed:

- 60% of respondents reported living alone,
- Nearly two-thirds (63%) are neither partnered nor married
- Only 15% had children and of those with children only 9% have children who are available to help them.

Living alone with weakened or unreliable support networks puts LGBT seniors at particular risk for not having full access to needed services as described in the 2012 DAAS Needs Assessment:

- One-third of participants reported poor general health;
- 42% had one or more physical disabilities; and
- 15% had seriously considered taking their own lives in the past 12 months.

While services and solutions exist within the network of aging-related services in San Francisco, the coping mechanisms that many LGBT older adults have developed over their lifetimes are based largely on a legitimate distrust and deeply rooted fear of the health providers, psychologists, hospitals, and community services that comprise this very network.

1. Lesbian and gay seniors are much more likely to be childless, single and living alone than their heterosexual counterparts. The consequences of increased isolation are increased vulnerability and risk for emotional and physical problems.

2. **Since 80% of caregiving and support** is provided by adult children, spouses or other family members, it is no surprise that gay and lesbian seniors often cannot identify someone to care for them in old age. **Almost 15 percent of gay and lesbian seniors in San Francisco** could not even identify someone to contact in case of emergency. Without live-in care, such as a partner or child, lesbian and gay seniors are less likely to take advantage of high-quality care and related services.

3. Economic and legal discrimination over the lifespan means that **LGBT seniors are significantly more likely to live in poverty** than their straight counterparts. (women, POC, trans most likely). Also, elders who live alone are much more likely to fall into poverty than are partnered people. Because so many gay and lesbian seniors live alone, the risk of poverty is that much higher for them, which, in turn, makes affording health-related services more difficult.

4. **Lifetime suicidal ideation** rates are significantly higher for LGBT people than straight counterparts with transgender people reporting highest rates (D'Augelli & Timothy, 2011). Suicide rates are higher in the senior population overall, esp. men 80+. Though we often talk about suicide risk in youth, how often do we consider the intersection of age and LGBT identities when we think about suicide risk? SIMILARLY, other risk factors include a higher incidence of drug and alcohol abuse for LGBT elders.

5. The LGBT community experiences **higher rates of PTSD and PTSD traits** than their straight counterparts. This may contribute to significant health disparities whereby LGBT seniors have worse health outcomes when compared to their straight counterparts. An Openhouse study in 2006 found that disabling or chronic health problems such as asthma or diabetes among lesbians and gay men were reported at rates usually seen in people a full decade older.

Key Content
What is your reaction to these statistics? Did any of them surprise you? What does this mean for your work and/or organization?

MODULE 4:

Traditional Linkages/Binary VS. Identity Spectrum/Continuum

Key Content
In this section, we will review a framework introduced to you in the online module to understand terms and concepts that are fundamental to LGBT identities.

JAZZ VIDEO HERE.
LINK: **www.youtube.com/watch?v=7S5usRgY720**
What thoughts or emptions are brought to the surface hearing Jazz describe her experience? How does her experience help you better understand what transgender elders in your organization may experiencing?

TRANS SUPPORT GROUP VIDEO HERE.
LINK: **www.youtube.com/watch?v=n7cq8Gezx4Y**
What thoughts or emotions are brought to the surface hearing folks describe their experiences as transgender people? What kids of additional supports might transgender elders need?

MODULE 5:

Historical Context

Key Content
The next section invites us to explore how our histories shape our sense of how we might be treated in the world. Understanding a senior's history will help providers work more effectively with aging LGBT folks.

LGBT Senior Vignette 4: *Dion*
My name is Dion. I represent the "G" in LGBT, but as a Chinese American born and raised in San Francisco, my experience may be somewhat different from that of other gay Americans. I think this is because of culturally "straddling the fence", so to speak. My parents are first generation Chinese immigrants and very traditional and I myself, had a Chinese American cultural upbringing.

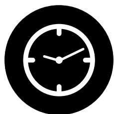
Being born in the early 1940s and raised in the 1950s, I had no idea I was gay. For one thing, the term "gay" was not used then, and, particularly in the Chinese community, the topic was not broached. It was truly "the love that dare not speak its name." There was no word I knew that applied to this concept, and without a term for it, I could not conceptualize it.

Near the end of my college career, gay people began to express their true sexual identities and groups began to spring up in especially in the Bay Area. It was only then that I realized that my sexual orientation was partly named for me. Due to society's intense negative views of homosexuality, including my own ethnic community, I sublimated my feelings and dated women like my friends did, hoping it would go away. Sharing my dating experiences with my friends was very revealing for me because I noticed that my sexual intensity with the opposite sex was never as strong as that of my friends. Even then, I resisted admitting this to myself.

After college graduation, I started my teaching career with the San Francisco Unified School District, where I remained until I retired. As a new teacher, I spent most of my time with career-related matters which allowed me to push aside my social and love life. Now I realize that I simply did not want to deal with my homosexual feelings. However, once I became more settled in my career and teaching became more of a routine, I had more time to think about and eventually confront my sexuality.

While the political climate of anti-gay witch hunts was occurring at the time, I decided to be true to myself, a philosophy that I've always followed since, and came out as gay. I started to sample various aspects and venues of the local gay scene. Being a non-drinker and non-smoker, bars did not appeal to me so I ended up using newspaper ads to meet other gay men. Through this route, I met a number of gays and some became good friends. In a few cases, they turned into relationships of various durations, but not until 1995 did I find a permanent one. We have now been together 21 years, and we consider ourselves very fortunate because our families have accepted us very openly. The fact that we are both of Asian ethnicity minimized cultural conflicts and maximized family acceptance.

Key Content
LGBT Seniors have seen a lot of change. In the online module participants had the opportunity to click through a historical timeline of events that impacting LGBT older adults in the past fifty years.



LGBT Historical Timeline (Handout). LGBT older adults in the United States have lived through common historical events that had particular effects on them as individuals and on their community. Those events have helped shape who they are, just as the events we have lived through have shaped who we are.

MODULE 6:

Isolation VS. Inclusion

Key Content

Understanding our own experiences of inclusion and what would have helped us in these moments, can help providers connect with a client's history of social stigma. While listening to Marge's story of isolation participants were asked to think about what isolation looked like for her.

LGBT Senior Vignette 5: *Marge*

Oh, hello there! I'm Marge. I was born in 1948 in Albuquerque, New Mexico. I am a lesbian – a two-spirit woman, as we say. I always knew that I wanted something different, I mean, I knew I liked women the way that other women liked men, but it just wasn't allowed back then. You couldn't mention it, and if you did, you could be put in an institution, fired from your job, or even arrested, just for sitting in a bar with other women like me. So, I got married young – like you were supposed to. The man I married was decent and kind, a good man, and we had three wonderful children. Things changed as I got older though – I realized that I wasn't being true to my real self. And the world around me changed as well – when I was 25, being a lesbian finally stopped (officially, at least) being a mental illness. Even so, it took several decades, and my kids growing up, before I became more comfortable with who I really am. Eventually, I decided that I needed to be truthful to my husband, and we ended up getting divorced. It was hard, but he was, at least, understanding. We still have a decent relationship – we do holidays and family things together.

I started to meet other women that had similar experiences to myself, but I was careful about who I told about the nature of the divorce and myself. I retired from teaching several years ago – and the whole last part of my career was fraught with worry about whether or not someone would find out about me, and about why I had divorced my husband. I didn't want to lose my job. I don't feel like I have that many close friends, or that many people that I trust. Sometimes, it can be really depressing.

The world has changed so much since I was young – one of my sons came out as gay right after college – and I think that got me started thinking about my life. I recently went to an event with him at the local LGBT community center, but it really wasn't for me. All these attractive young people hanging around and talking, and I felt like such an old lady. I think they were interested in my story, but I just didn't share much. The residual shame from my youth can be hard to shake off. Young folks today don't always realize that it wasn't that long ago that the shame and stigma attached to being gay could literally ruin your life.

In the online module following Marge's story, participants were asked to think of a time in their life when they didn't feel included because of being different from or "other" in relation to the people around them. Participants were asked to write down their responses to the following questions about their experience:

- How did it affect who you could "be"?
- What assumptions might they have made about you?
  What assumptions did you make about them?
- How did you feel? How did you act?
- What did you do to cope in this situation?
- What would have made the situation better for you?
- If someone wanted to support you, what could they have done?

For many of us, the intervention that may have made a difference would have been someone standing up for us. This is what we call being an "ally."

Definition of ally: Someone who supports and stands up for members of a community other than their own, reaching across differences to ensure the rights and dignity of all.

REVIEW OF ONLINE MODULE

Key Content

As we work towards creating a more inclusive, equitable environment, it can seem like there is a lot of work to do. Let's review what has been covered today.

We began with common assumptions that prevent LGBT elders from feeling fully seen, welcomed and valued, changes to main points this continues with each box as the subjects are revisited.), and then moved on to the differences between cultural humility and cultural competency. We looked at LGBT aging statistics, and reviewed terms and concepts; we explored outdated binary categories as opposed to viewing identities along a continuum, and we looked at a historical timeline, placing each of the senior experiences in a social and political context. Lastly, we reflected on our own experiences of inclusion to better understand the impact on our LGBT senior clients.

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