Lesbian, Bisexual, and Two-Spirit Women's Experiences of Congregate Later-Life Housing in an Atlantic Canadian Continuing Care Organization

by

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Submitted for partial fulfillment of the requirements
for the degree of Master of Arts

at

Dalhousie University
Halifax, Nova Scotia
August 2024

Dalhousie University is located in Mi'kma'ki,
the ancestral and unceded territory of the Mi'kmaq.
We are all Treaty people.

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Dedication

This thesis is dedicated to Laura Blinn,
the smartest and kindest person I know,
and sweet Clementine.

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Abstract

As the Baby Boomer generation reaches old age, there is increased demand for later-life housing options that reflect their unique cultural context. Therefore, it is vital to consider the experiences of LGBT and Queer Baby Boomers, who have been largely invisible in existing continuing care models and social science literature. This thesis is a case study of older lesbian, bisexual, and Two-Spirit women's experiences in an independent living and long-term care facility in Atlantic Canada. Based on qualitative interviews with older lesbian, bisexual and Two-Spirit women, contextualized by observations made during a gay-straight alliance group in the long-term care home, this thesis seeks to understand the experiences of LGBT people living in later-life housing facilities and how they can be better supported in their place of residence. Participants' experiences are influenced by general challenges associated with aging, such as a decreased ability to complete activities of daily living; however, their experiences are uniquely shaped by the political climate of 2SLGBTQ+ issues throughout their life course, and the onset of the COVID-19 pandemic. Findings from this thesis offer insights toward creating inclusive later-life housing options for 2LGBTQIA+ people, specifically by acknowledging the heterogeneity of this population, their needs, and their desires to live autonomously in later life. This thesis contributes to existing literature that emphasizes the need to recognize generational contexts in inclusion strategies and offers critical considerations for 2SLGBTQIA+ inclusive later-life housing options.

List of Abbreviations Used

2SLGBTQIA+: Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and all other sexual and gender minority identities (+). Other variations of this acronym are used throughout this thesis (e.g. LGBT, LGBTQ+) to signal specificity when relevant.

ADLs: Activities of Daily Living

AIP: Aging in Place

GSA: Gay-Straight Alliance

LTC: Long-Term Care

LTCF: Long-Term Care Facility

Acknowledgments

First and foremost, I would like to acknowledge the invaluable contributions of my participants – I quite literally couldn't have done it without you! Beyond the contributions to my thesis, I am thankful for the connection I shared with each of you. As a young queer person, I rarely have the opportunity to engage with older members of the community. Being welcomed into your homes, having loads of tea, listening to your animated stories, and meeting your beloved animals are experiences I will always hold near to my heart.

I would like to thank my supervisor, Liesl Gambold, for helping me grow as a person and researcher. I am grateful for how welcome you made me feel as a new MA student, and for all the time, energy, and pen ink you have used since I started the program to help me get to this stage. Thank you to my committee member, Martha Radice, for your enthusiasm toward my project and the insightful feedback you provided me throughout this degree. I would also like to thank my third committee member, Elizabeth Fitting, for your kindness each time I saw you and the knowledgeable feedback you provided on my thesis.

I would like to thank Fabrizio Antonelli, Ardath Whynacht, and Erin Fredericks for their incredible mentorship, pep talks, warmth, camaraderie and for keeping my bills paid through all the work you have provided me. I am eternally grateful to each of you, and I cannot thank you enough.

Thank you to my dear friends and peers who have supported me throughout this stage of my life. A special thank you is owed to Joseph Lahey, Laura Blinn, and Rachel Giffin, for the love, tenderness, and, dare I say, *kinship* you have given me. While I am beyond thankful for the continuous support in the program, I will forever treasure the bonds we have created outside of it. I am the luckiest person in the world to have friends like you three.

Thank you to my dear partner J for all the meals you cooked when I was in a deep ADHD style of focus, for sleeping on the couch to keep me company when I worked late at night, and for engaging with every thesis- and research-related thought I shared with you – no matter how existential. I couldn't have done this without your unwavering support.

Lastly, I would like to thank myself for the hard work I put into this thesis. I am proud of the growth I had throughout this program, and I am excited about the future ahead.

CHAPTER ONE: INTRODUCTION

Canada's largest age cohort, the Baby Boomers, celebrated an important demographic milestone in 2021, marking the first year that members of this generation turned 75 (Statistics Canada, 2022) and, ultimately, signalling this cohort is on the horizon for entering into later-life housing. The Canadian population has been aging at an unprecedented rate, with one in five aged 65 and older in 2021, and projections suggest that this will increase to one-quarter of the population by 2051 (Statistics Canada, 2022). As the population continues to age, there will be an increased demand for a diversity of later-life housing options that recognize and accommodate aging adults' changing needs. An integral part of meeting these needs is implementing relevant social policies and care models that promote inclusivity, safety, and autonomy.

As the Baby Boomer generation ages, there is an out and visible population of older lesbian, gay, bisexual, and transgender (LGBT) people for the first time (Ramirez-Valles, 2016). Some social scientists assert that the aging of this generation is as "world-shattering as the gay liberation and AIDS movements were" due to the traditionally non-intergenerational nature of the LGBT community[1] (Ramirez-Valles, 2016, p. 3; Heaphy, 2007). While lesbian, gay, bisexual, and transgender people have always existed, LGBT and Queer[2] members of the Baby Boomer generation came of age during the gay liberation movement, creating the first cohort of

[1] While scholars have argued that the LGBT and Queer community have always created intergenerational, non-biological kinship relations through what Kath Weston (1997) famously coined "families of choice," others have drawn attention to the lack of intergenerational contact within the community, noting how LGBT interactions tend to be age-segregated (Morris et al., 2023; Ramirez-Valles, 2016; Russell & Bohan 2005; Weststrate et al., 2023).

[2] Throughout this thesis, I often use LGBT and Queer interchangeably. The rationale and context for this are included near the end of the introduction.

openly LGBTQ+ people in North America. As members of this cohort, who scholars like Ramirez-Valles (2016) playfully call Gayby Boomers, continue to age, later-life housing organizations and initiatives must consider the unique cultural context of LGBT and Queer older adults to provide them with an inclusive, safe place to call home.

As efforts are made to create social policies and care models that can support increased demand for later-life housing, traditional theories of aging are being re-examined. However, these theories have been systematically informed and maintained by a dual silencing: that of sexuality in theories of aging and of aging in theories of sexuality. These dual acts of silencing have rendered LGBT and Queer older adults invisible (Brown, 2009; Twigg, 2004). This dual silencing extends beyond social science literature and perpetuates the invisibility of older LGBTQ+ adults in the broader literature on LGBTQ+ people's lives. For example, in Kia et al.'s (2019) review of the experiences of poverty among sexual and gender minorities across Canada, they conclude that social science literature regarding the lives of older LGBT people is scant. Within this already limited literature, the majority focuses on LGBT people born prior to 1946 rather than the experiences of aging Baby Boomers (Frederiksen-Goldsen et al., 2013; McGovern & Vinjamuri, 2016). This invisibility is concerning, as it results in the exclusion of older Queer people from research on both the wider 2LGBTQIA+ and older adult communities, as well as health and social services that serve them, like later-life housing services (Cahill & South, 2002; Cook-Daniels, 1997).

The gap in the literature becomes further pronounced when looking at later-life housing for LGBT older adults, especially in the Canadian context. Redden et al. (2023) attribute this gap in research on the needs and experiences of LGBT older adults in later-life housing settings to the "systemically precarious social conditions shaping the lives of older LGBT adults," and, like

myself, they find it "surprising that Canadian scholarship, policy, and practice addressing LGBT aging and housing remains scarce" (p. 114). The few studies that are focused on LGBT older adults' experiences of later-life housing are primarily concerned with LGBT older adults who are residing independently in the community and their fears about entering into congregate living settings, such as long-term care facilities (Furlotte et al., 2016; Savage & Barringer, 2023; Westwood, 2015; Wilson et al., 2018), or focus on long-term care home staff and administrators' interpretation of LGBT and Queer residents' experiences of long-term care (Kortes-Miller et al., 2018; Sussman et al., 2018).

With this context in mind, my thesis explores older lesbian, bisexual, and Two-Spirit women's experiences in an independent living and long-term care facility in Atlantic Canada. This study was guided by two research questions: *How do older LGBT adults describe their experience transitioning into and living in later-life housing facilities (i.e., independent living, assisted living, and long-term care), and how, specifically, do they describe their sexual identity as influencing these experiences?* Second, *How can residential facilities better support LGBT and Queer residents?* To answer these questions, I employed two qualitative research methods: (1) writing descriptive observational notes while at the long-term care facility, including during an organized, yet poorly attended, gay-straight alliance group, and (2) conducting semi-structured interviews where participants were asked about their experiences transitioning into their current residence, and how they understand the role of their sexuality in navigating this transition.

In this thesis, I use the term 'older adult' to refer to people who are part of the Baby Boomer generation and older. Also, I use the terms LGBT (Lesbian, Gay, Bisexual, Transgender) and Queer to describe sexual and gender minorities. However, I also use the

2SLGBTQIA+ (Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and other gender and sexual minorities (+)) acronym when I am discussing research that is representative of this larger population. Often, I use the terms LGBT and Queer relatively synonymously to avoid asserting presentist language onto older age cohorts, given that identity labels, such as Queer, that are commonly used by younger 2SLGBTQIA+ people, are often not embraced by some older 2SLGBTQIA+ community members a part of the Baby Boomer generation and older. The term "Queer" was – and still is – used as a pejorative slur to stigmatize those who are perceived as a part of the 2SLGBTQIA+ community. Some older adults experienced violence from this slur prior to its reclamation, when it was used to shame, humiliate and degrade them. However, the intentional use of Queer as an identity label has grown in recent decades, especially amongst younger people who are "college-educated, liberal, and social justice-motivated" (Worthen, 2023, p. 2). Despite the reclamation of "Queer" as an identity label amongst younger age cohorts, it may create discomfort amongst older cohorts who could have been a target of the slur and find it offensive as an identity label. Despite these cohort tensions in using Queer as an identity label, or reclaimed slur, I intentionally use Queer in my project. Many residents living at the housing facilities involved in this project spoke about friends and family who are older adults and who identify with the term. Further, Queer can function as a broad term for those unsure of their gender and sexual identities, as well as those who identify with terms apart from distinct categories of lesbian, gay, bisexual, and/or transgender.

This thesis is organized in the following chapters. Chapter One is a literature review of four key research areas, with each successive section narrowing in on the focus of this study – aging, housing, LGBTQ+ aging, and lastly, LGBTQ+ people's experiences of later-life housing. Chapter Two discusses the research methods employed for this project, including insights into

site selection and recruitment, the two qualitative research methods used, data analysis, and ethical considerations. Chapter Three begins by setting the scene of participant interviews, and then presents the key themes that emerged in qualitative data analysis of the reflexive notes from the GSA sessions and participant interviews. Chapter Four interprets these findings using social science literature, drawing connections between generational contexts, general challenges and desires for later-life housing, and specific opportunities to support older LGBT and Queer adults in their experiences of moving into and residing in later-life housing. Finally, Chapter Five will conclude with implications, limitations, and proposed avenues for future research.

CHAPTER TWO: LITERATURE REVIEW

This thesis is informed by two key bodies of social science literature, namely, aging and housing, and the experiences of LGBT and Queer people as topics in this scholarship. Ergo, the following chapter is divided into two sections. The first lays a foundation of relevant age- and housing-related themes in social science literature, while the second nuances the unique experiences of LGBTQ+ people within these areas. In turn, the first section will begin by addressing social science literature on aging, first by defining age and aging and then by considering two key theoretical perspectives: age stratification theory and the life course perspective. This will be followed by a discussion on relevant themes in social science literature on housing, including a brief discussion on the conceptual components of housing, followed by housing considerations and options in later life. The second section will begin by exploring social science literature on LGBTQ+ people's experiences of aging, first by briefly discussing the emergence of the field, then by considering the ways LGBTQ+ people experience aging differently, drawing on two key theories of queer aging: accelerated aging and crisis competence. This section and literature review will conclude by addressing the experiences of LGBT and Queer people in later-life housing to provide the necessary foundation for this thesis.

Aging

Age and aging have long been recognized as a fundamental element in social structure and the life course[3], yet they are contested terms in the social sciences (Elder, 1975; King, 2016; Laz, 1998; Novak et al., 2018; Neugarten & Neugarten, 1986). Early understandings of age and

[3] Within sociology, there has been a focus on the life course as a means to distinguish age and processes of aging from biological and psychological models, such as the lifecycle or lifespan, which assume a series of predetermined developmental stages (Crosnoe & Elder, 2002; King, 2016)

aging were thought of as a product of biological, "objective" processes, as researchers in Western "natural sciences" (e.g. developmental biology) were concerned with observable, physiological processes (Laz, 1998, p. 86). As aging research continued, age was understood beyond physiological changes occurring in the body and became inclusive of "psychological aging," which refers to age-related developmental changes in emotional and cognitive functioning (Powell, 2006, p. 18). By combining physiological aging with psychological aging, age was maintained as a discrete, chronological, biologically determined marker. In turn, aging was generally considered to be the process of passing through chronological ages – and was, in effect, the one "inevitable" truth of every person's life (Powell, 2006, p. 25; Butler, 1969; Laz, 1998; Novak et al., 2018).

Positivist inquiries propounded biological and psychological traits of age as "an expedient index of social age" until the 1970s, when the social constructivist perspective was introduced to aging research (Neugarten & Neugarten, 1986, p. 32; Foner, 1978; Laz, 1998; Powell, 2006). This perspective asserted that age is socially constructed in that its social meaning is a product of society and culture, which varies across time and space (Calasanti & Slevin, 2001; Johfre & Saperstein, 2023). Calasanti and Slevin (2001) contextualize this social constructivist shift by stating how "prior to the twentieth century, there was no term for adolescence" (p. 14). Before adolescence was designated as a life stage, young people arrived at adulthood and its associated responsibilities (e.g. full-time employment) at considerably younger ages than in today's Western societies (Calasanti & Slevin, 2001). This social constructivist shift, as exemplified by the emergence of adolescence as a life stage, is key to understanding the influence of history, technology, and culture on the field of aging research.

However, aging is "not just a product of Western modernity" (Powell & Hendricks, 2009, p. 85), and its social construction becomes further apparent when examining cross-cultural depictions of old age. A common point of comparison for these cultural differences in aging within social science literature is between Western and Asian cultures (Fung, 2013; Sung, 1995). Unlike Western cultures, social science literature suggests that Asian cultures tend to regard aging positively, as respect for older people was an integral part of Confucian doctrine (Powell & Henricks, 2009). In fact, a core virtue of Confucian philosophy is filial piety or *xiao*, which refers to adult children's moral obligations, commitments, and behaviours towards their aging parents (Löckenhoff et al., 2015; Sung, 1995). Social scientists (Fung, 2013; Sung, 1995) note that these filial values are "a human universal," however, it has been argued that they have increased salience in Asian cultures (Löckenhoff et al., 2015, p. 328). This East-West dichotomy as a method of inquiry in aging research has been cautioned against as a means of comparing cultural values, as it ignores the role of "economic contingencies and population structures" (Löckenhoff et al., 2015, p. 322). However, for the purpose of this thesis, this dichotomy highlights the profoundly cultural nature of aging and, in turn, affirms age as a social construct.

With this context in mind, throughout this thesis, I use the words "age" and "aging" in their broadest sense. As Laz (1998) suggests, age is not the property of older adults; instead, it is relevant to people of all (chronological) ages. In this regard, age must be understood as "situated, contingent, and negotiated, and as continually constituted in interaction" (Laz, 1998, p. 100). In turn, when I refer to "age," I am acknowledging age as an individual chronological attribute that is used to assign age-related social roles, while also recognizing age as being socially constructed. Similarly, when I refer to "aging," I emphasize it to be a life-long process attributed

to the progression of chronological age while also recognizing aging as socially constructed, given that social norms, roles and symbols surrounding aging vary cross-culturally.

Theories of Aging

The notion that aging was a "problem" that needed to be studied emerged during the late 1930s (Estes & Binney, 1989, p. 589) in response to a surge in public interest toward academic research and the resultant public policy initiatives designed to purportedly solve the problem of aging. At the time, the problem of aging was focused on the "circumstances of aging," which were focused on physiological (e.g., increased frailty) and psychological (e.g., cognitive impairment) changes in the body (Estes & Binney, 1989; Hendricks & Leedham, 1991; Lynott & Lynott, 1996). As public interest continued to rise, researchers were inhibited by a lack of a "generally accepted paradigmatic perspective, and even a concept of what aging is," that could serve as a common frame of reference across academic disciplines (Estes & Binney, 1989, p. 589). Consequently, research efforts were directed toward operationalizing aging in hopes that once established, this understanding could inform eventual research for age-related public policy initiatives. With this goal in mind, researchers began developing theories of aging to serve as a shared frame of reference.

Early work in the 1940s and 1950s laid an essential foundation for the first formal theory of aging[4], which materialized in 1961. During this time, the language of "theory" was absent in much of the sociological research on aging, and social scientists' focus was the "object of an

[4] The development of theories of aging can be separated into three generations. These generations represent the shift within the field of aging from its positivist roots to employing a social constructionist perspective. For instance, first-generation theories concentrate on individual adaptations to the "circumstances of aging" (Hendricks & Leedham, 1991, p. 4), whereas third-generation theories suggest that older adults age differently because of the allocation of material and social resources (Hendricks & Leedham, 1991; Maddox, 1987).

implicit, unidimensional way of thinking about aging," which meant that research was focused on individual adaptations to age-related physiological and psychological changes (Lynott & Lynott, 1996, p. 750). With this practical orientation to understanding the "facts" of aging, early researchers described aging as a process whereby individuals must adjust themselves to the problems forged by changing social roles (Cavan et al., 1949; Havighurst & Albrecht, 1953; Lynott & Lynott, 1996; Maddox, 1987). These purported problems were not determined by social structures of domination or the conditions of these structures (e.g., poverty, social isolation, poor health), as these were "natural conditions" that were accepted by researchers as "the way things were, the facts of elderly life" (Lynott & Lynott, 1996, p. 750). Instead, these problems were the product of older adults growing dissatisfied with their lives due to an inability to achieve the standard of well-being marked by an activity-oriented, work-related lifestyle. These alleged facts of aging informed many of social scientists' first formal theories of aging, which were focused on social involvement and physical well-being in later life (see Atchley, 1971; Cumming & Henry, 1961; Havighurst & Albrecht, 1953).

As theories of aging continued to develop, social scientists became interested in understanding age as a variable in social inequality. Amongst the most popular of these theories is the aging and society paradigm, also known as age stratification theory. Developed by Matilda White Riley (1971), age stratification theory argues that age is essential to understanding social inequality. To understand age as a criterion for social organization, Riley (1971, 1972) proposed two key concepts: age cohorts and cohort flow. Age cohorts are a group of people born in the same period of time (e.g. between 1950 and 1955) who, consequently, move through stages of the life course together (Riley et al., 1972). Cohort flow refers to the process of transitioning through age grades (e.g. adolescence, adulthood) as a person ages (Riley et al., 1972). For the

purpose of this thesis, these concepts provide the foundation for understanding age stratification as a basis for social organization and the inequality it produces. More specifically, this social organization follows a curvilinear course, whereby the transition out of youth into adolescence is marked by increasing social rewards through middle age which, for most people, declines as they transition out of middle age into old age (Foner, 1978; Riley et al., 1972).

This age-stratified social organization has implications for the life course as age grade transitions, and their associated social rewards, shape experiences of identity and inequality as people age. In recognition of this, Glen Elder developed (1975) and formally proposed (1988) the life course perspective. This theory suggests that aging is a process of compounding experiences whereby events and conditions early in life can affect later life (Elder, 1975, 1988; Novak et al., 2018). By virtue of this, old age is understood as a unique life period and as the cumulative product of earlier stages in life. Likewise, the experiences of old age will differ based on individuals' life transitions and trajectories.

Life transitions and trajectories are critical components of the life course perspective. Life transitions refer to changes in social status or roles (Novak et al., 2018), such as marriage, divorce, and widowhood, and are "always part of social trajectories that give them distinct meaning and form" (Elder, 1988, p. 2). These life transitions have implications for experiences of identity as people age, as social roles are unique to each life stage (e.g. adolescence, adulthood, old age) and, by extension, are assigned based on an expected sequence of life events. These roles are a product of internalizing "social clocks" that prescribe expected – and therefore, normal – timelines for major life transitions. Individual identity becomes constructed and affirmed by being "on time" for these life period milestones; for example, a young man may feel he "will be a failure if he does not 'make it' in his corporation by the time he is thirty-five"

(Neugarten & Neugarten, 1986, p. 39). Ergo, individuals who are "off time" are assumed to be "doing poorly for their age," negatively impacting experiences of identity (Neugarten & Neugarten, 1986, p. 39).

I retain age cohorts and the life course perspective as the most important elements of theories of aging for my study. Age cohorts are essential to understanding the influence of participants' generational location on their experiences as a LGBTQ+ person. Moreover, the life course perspective is crucial for my study, as it suggests that aging is a process of compounding experiences whereby events and conditions early in life can affect later life, and in turn, emphasizes later life as a unique life period and the cumulative product of earlier life. For my thesis, this perspective is especially important since LGBT and Queer people report distinct life events from their heterosexual and cisgender peers, which will be discussed further in the second section of this chapter.

Population Aging

Life trajectories often include many life transitions; however, trajectories have a more macro-level focus on long-term patterns of stability and change (Elder, 1988). These trajectories are influenced by historical and social contexts. A prominent example of this is population aging, a global phenomenon that refers to decreasing fertility and mortality rates and a rise in the median age of the population (World Health Organization, 2023). Worldwide, there has been a rapid increase in the proportion and absolute number of older people (World Health Organization, 2023). In the Canadian context, this can be explained by two birth rate phenomena – the "Baby Boom" and the "Baby Bust" – which account for the most significant changes in the Canadian population from 1946 to the present (Novak et al., 2018). The baby boom spanned 20 years (1946 to 1964), wherein there was "an explosion in the fertility rate" following World War

II, and the total fertility rate (i.e., children per woman) rose from 2.83 to 3.84 (Novak et al., 2018, p. 59). Individuals born during this time have had their generation labelled accordingly as the "Baby Boomer Generation," or in its shortened form, "Boomers." Following this increased fertility, Canada went into a baby bust, marked by a stark decrease in the total fertility rate, dropping from 3.84 in 1961, to 2.81 in 1966, and then to 1.51 in 2000 (Novak et al., 2018).

Baby Boomers have since progressed through the life course and, in doing so, have redefined standard life trajectories. Members of this cohort were far more likely to obtain a post-secondary degree and, in turn, hold a "white collar job" compared to earlier cohorts (Eifert et al., 2016, p. 177). Further, women apart of this cohort were more likely to be employed outside the home (Eifert et al., 2016). As people continue to live much longer than the average age of death in previous generations (Gilleard & Higgs, 2011; Novak et al., 2018), Baby Boomers are redefining old age. Novak et al. (2018) describe that while sayings like "'60 is the new 40,' and '70 is the new 50' may have begun as clever remarks," they describe the reality of aging today (p. xii). Through increased education about better health and nutrition, and advances in medicine, the middle age has been extended, meaning that Canadians can be retired, be in relatively good health, and engage in meaningful and social activity for longer (Gilleard & Higgs, 2010, 2011; Novak et al., 2018). Along with a longer middle age is an increase in the population of the oldest-old, with more people reaching record chronological ages. Members of this oldest-old group, compared with people aged 65 to 74, "show higher rates for institutionalization, disability, and poor health" (Novak et al., 2018, p. 63). As the older population increases in size, and the prevalence of chronic illness and disability amongst members of this cohort rises in tandem, there is a surge in demand for a diversity of later-life housing options that can accommodate older adults' changing needs.

Housing

Social science research has explored the topic of housing since the early 1900s and has evolved into a vast area of scholarship (Dunn, 2000; Foley, 1980). The field of housing, like aging, is considered to be an interdisciplinary topic, with insights commonly being drawn from anthropology, architecture, geography, and philosophy (Gillsjö et al., 2011). Key themes in housing research often include, but are not limited to, housing's influence on family life (see Back, 2015; Downs, 1977), identity (see Byrd & Chavous, 2009; Gram-Hanssen & Bech-Danielsen, 2007), urban development (see Downs, 1977; Gottdiener & Feagin, 1988), and housing policy and governance (see Clarke & Parsell, 2020; Fertig & Reingold, 2007). Considering the scope of this thesis, the following discussion will be focused on later-life housing options.

Within social science literature, housing was initially defined as simply an individual's physical shelter (Foley, 1980). However, as this field has evolved, there is increasing recognition that housing comprises more than built infrastructure and instead comprises the "broader residential setting" (Foley, 1980, p. 457). In turn, an extensive amount of literature has emerged that draws a conceptual distinction between "house" and "home" (Bigonnesse, 2014; Cater et al., 2022; Gillsjö & Schwartz-Barcott, 2011; Leibing et al., 2016; Oswald & Wahl, 2005). While, as mentioned, "housing" refers to the material, physical, built environment (i.e., infrastructure), the "home" is affectively motivated, often understood as an attachment to place (Gillsjö & Schwartz-Barcott, 2011; Leibing et al., 2016; Oswald & Wahl, 2005; Rowles, 1983). This "place" can be physical, including the built environment of housing, and it can extend into one's neighbourhood or wider community, including a city, region, or country (Leibing et al., 2016). Further, this attachment to place expands beyond physical environments to include social aspects

and “autobiographical insideness,” which asserts that a place is an extension of oneself (Rowles, 1983, p. 299; Cater et al., 2022; Oswald & Wahl, 2005). These distinctions of house and home are often made to assert that housing-related choices (e.g., housing transitions and trajectories) are not made independently based on the built environment and, instead, are influenced by the meaning attributed to the home.

Feeling “at home” is a critical part of wellness for older adults, as it provides a sense of belonging (Cater et al., 2022; Gillsjö et al., 2011; Oswald & Wahl, 2005; Rowles, 1983). Here, belonging refers to the “experience of personal involvement in a system or environment” (Prieto-Flores et al., 2011, p. 1183). With the home becoming “central to daily life, as it becomes the base of activity as many grow old” (Gillsjö et al., 2011, p. 1; Oswald & Wahl, 2005), the vast majority of Canadians desire to age in place (AIP), with some estimating that upwards of 85% of older adults would prefer to AIP (Cao & Hou, 2022; Channer et al., 2020). The US Centers for Disease Control and Prevention (CDC) defines aging in place (AIP) as “the ability to live in one’s own home and community safely, independently, and comfortably, regardless of age, income, or ability level” (CDC, 2009, as cited in Cao & Hou, 2022, p. 256). More recently, AIP has been broadened to include transitions from one’s current home into a new environment of their choice, outside of institutional settings, where people feel that they belong (Cao & Hou, 2022, p. 257; Hillcoat-Nallétamby & Ogg, 2014; Pani-Garreman et al., 2020). Downsizing from one's single-family home into a smaller place, such as an apartment in an independent living facility, can be understood as accommodation for aging in place (Abramsson & Andersson, 2012). This downsizing is often paired with accessing continuing care services, such as home support (e.g. personal care and essential housekeeping) or nursing care (dressing changes, catheter care, intravenous therapy) (Nova Scotia Department of Health and Wellness, 2024a). By

making accommodations to AIP, people can remain independent for longer, allowing them to stay in their home and their community.

For older adults, an embodied awareness of every aspect of their physical environment – and their involvement in it – becomes an essential tool in adjusting to changes in health, ability, and support (Oswald & Wahl, 2005; Rowles, 1983). In a Canadian study with 392 community-dwelling older adults, caregivers, and service providers, participants spoke about how the meaning of home is influenced by older adults' capacities to complete activities of daily living (ADLs), such as bathing, cooking and getting dressed (Bigonnesse et al., 2014). As part of these ADLs, older adult participants valued "still being able to take care of their home," as this maintenance acted as a source of pride and, in turn, facilitated feelings of belonging (Bigonnesse et al., 2014, p. 372). Participants spoke about an anticipated decline in their ability to keep up with home maintenance and other ADLs as they aged, particularly after the loss of a spouse (Bigonnesse et al., 2014). Since these tasks would need to be entirely undertaken by the surviving partner, older adults may seek out paid services (e.g., landscaping, snow removal, cleaner) to help maintain their home. However, the cost of home maintenance services is a concern for many older adults, especially for those on a fixed income such as Old Age Security or Canadian Pension Plan (Beer & Faulkner, 2011; Bigonnesse et al., 2014). Despite a preference to age in place, unaffordable home services, changing health needs (e.g. increased frailty impeding the ability to complete activities of daily living), and social situations (e.g., caregiver illness or death) may require individuals to consider a housing transition (Bigonnesse et al., 2014; Gillsjö & Schwartz-Barcott, 2011; Rockwood et al., 2014).

Later-Life Housing Transitions

Housing transitions describe the ways people "live in, use, and consume housing over the course of their lives" (Beer & Faulkner, 2011, p. 15). Housing transitions (i.e. moving) enable people to adjust their residential location to meet changing needs and preferences (Beer & Faulkner, 2016; Coulter et al., 2011; Kan, 1999; Kley, 2011). These transitions are informed by subjective factors, such as the meaning attached to the home, as well as more objective factors like family structure, home tenure status, and financial circumstances (Beer & Faulkner, 2016; Clark & Lisowsli, 2017; Coulter et al., 2011). As a result of these intertwined factors, it is important to note that moving is not a discrete event – rather, it is a process (Coulter et al., 2011). Social scientists describe this process as a series of steps, including "some form of preference-formation, deliberation, and destination choice processes" (Coulter et al., 2011, p. 2744; Kan, 1999; Kley, 2011). This process is often catalyzed by dissatisfaction with one's current housing, paired with the idea that moving would improve their well-being (Coulter et al., 2011). However, Kan (1999) reminds us that a move may be sudden or unplanned, like in the case of a sudden change in a health or economic crisis, undermining the possibility of completing this process.

Influences on housing transition-related decision-making vary across the life course. Generally, people are assumed to experience an increased capacity to express choice over their housing as they age, with the exception of adult-onset disability. In young adulthood and adulthood, when the household is "establishing itself" (Beer & Faulkner, 2011, p. 34), housing decisions are heavily influenced by lifestyle factors such as cultural norms, consumption preferences, and the potential for family change (Beer & Faulkner, 2011; Clark & Lisowsli, 2017). In later life, housing transitions are often influenced by the desire to live close to services and security in long-term housing. This, of course, is dependent on variables such as housing

availability and the absence of adult-onset disability (Clark & Lisowsli, 2017). In their seminal article, Litwak and Longino (1987) identified three types of residential moves for older people, which were proposed as successive stages in the life course: retirement moves (after parental duties become less relevant), comfort moves (in the face of moderate disabilities), and care moves (as a result of chronic, or "worsening" disabilities). The type of residential move is likely to determine the type of later-life housing accommodation. For example, individuals who do not require nursing care are likely to consider transitioning into an independent living facility.

Independent Living

As previously stated, aging adults may desire to transition into an independent living facility as an accommodation to age in place to help maintain independence (Abramsson & Andersson, 2012). An independent living facility is a type of congregate housing that is often similar to a typical apartment complex– it has private rooms and amenities (e.g. laundry, washrooms) and shared common leisure areas (e.g. lounge, gym). However, independent living facilities that are targeted toward older adults may be modified to include accommodations such as grab bars and railings to support aging adults (Leviten-Reid & Lake, 2016). Likewise, individual units are likely to be single-story to avoid fall risks associated with stairs[5] (Leviten-Reid & Lake, 2016). In addition to these accessibility features, older adults may transition into an independent living facility for socialization opportunities. Shared spaces such as common rooms and hallways have been identified as an important dimension of housing design for aging adults, as they facilitate social interaction (Cater et al., 2022; Leviten-Reid & Lake, 2016). These

[5] These accessibility measures are often absent in private facilities, as they suggest a decline in physical health, which is argued to mean the person is no longer independent. When these accessibility features are included, the independent living facility is often unaffordable for most older adults (Leviten-Reid & Lake, 2016; Weeks & LeBlanc, 2010).

shared spaces may also be designated for formal social programming offered by the housing provider (Leviten-Reid & Lake, 2016).

While outside of the scope of this research, it is worthwhile noting that some housing scholars (for example, Leviten-Reid & Lake, 2016; Redden et al., 2023) have proposed the implementation of an age-friendly housing design, often in the form of progressive housing. This type of housing would allow older adults to avoid multiple moves – for example, from their initial home to an independent living facility, and then to long-term care – and instead have a single facility that "would be affirming but also able to meet progressively complex health care needs as needed" (Redden et al., 2023, p. 127). However, at present, individuals who require additional support than what can be accessed in an independent living facility are likely to transition into long-term care (LTC).

Long-Term Care

The term "long-term care facility" describes the housing provided by organizations (private or public) where any amount of nursing care is provided. In Canada, long-term care facilities (LTCF) often have long corridors, shared bedrooms, and built-in services such as physiotherapy and recreational programming (Banerjee, 2007; Koncul et al., 2023). LTCFs may offer tiered care and housing options, often through assisted living and long-term care. Assisted living falls somewhere between institutional long-term care and home care (Novak et al., 2018). A person typically moves into an assisted living facility when they can no longer manage at home or in an independent living facility, but do not require around-the-clock nursing care. Conversely, long-term care refers to housing that provides 24/7, indefinite nursing and personal care for residents (Banerjee, 2007). These residents often have advanced dementia or are experiencing a considerable decline in their physical health (Penning et al., 2018; Rockwood et

al., 2014). Using administrative data obtained over a four-year period for clients aged 65+ (n = 2,951) who were admitted into publicly funded LTC facilities within Canada, Penning et al. (2018) found that those with greater cognitive and ADL impairment were most likely to move into long-term care. In turn, there is a diversity of health – and social – needs in LTC facilities.

While LTC is typically regarded as a necessary form of care for older adults with high support, it is important to note that these care homes are not solely for older adults (Koncul et al., 2023). Instead, they are for anyone who requires a higher level of support – including those whose care needs exceed what home care can provide, those whose family members are no longer able to provide care for them, or individuals whose health care status has changed and now require ongoing nursing services (Nova Scotia Department of Health and Wellness, 2024b). Therefore, LTC care homes often house disabled people of all ages who require a level of care that cannot be provided elsewhere (Herron et al., 2021).

Queer Aging

While there is ample literature on aging, demonstrating its complex, cultural, social, and temporal nature, there is limited social science literature concerning aging LGBT adults. Even within LGBT aging literature, the majority is concerned with the experiences of gay men rather than the LGBT community as a whole, disproportionately excluding the other identities (i.e., lesbians, bisexuals, and transgender people) that contribute to the group membership signalled by the acronym (Berger, 1982; Brown, 2009; Kelly, 1977; Meyer, 1995; Ramirez-Valles, 2016; Redman, 2012; Schope, 2005; Westwood, 2013). Recognizing that research on LGBT aging has only significantly advanced in the last couple of decades, this chapter will begin with a brief overview of early LGBT aging research to contextualize theories related to queer aging and the development of the field more broadly.

Emergence of LGBT Aging Research

The first wave of social science research on LGBT aging emerged in response to the hostile climate of LGBT issues. Following the Stonewall riots in 1969, there was a paradigm shift regarding homosexuality – proclaiming it as a group identity rather than an individual condition (Kimmel, 2015). Early research on LGBT aging in the 1970s and 1980s was born of a largely political agenda of visibility to challenge then-widespread homophobic discourse that promoted a deficit orientation to LGBT people and their lives (Berger, 1980; Fredriksen-Goldsen, 2016; Friend, 1990; Gabbay & Wahler, 2002; Kelly, 1977; Kimmel, 2015; Minnegerode & Adelman, 1978; Raphael & Robinson, 1981). To do this, early scholars sought to dispel pathologizing stereotypes of first older gay men, and then lesbians, as "lonely," "unhappy," and "leading unsatisfied lives" (Berger, 1980; Friend, 1990; Gabbay & Wahler, 2002; Ramirez-Valles, 2016). These myths were often rooted in the assumption that traditional structures of support, such as family, church, and community, were unobtainable for LGBT people (Friend, 1990).

Jim Kelly, a social work student at the University of Southern California, offered the first empirical challenge to this nearly homogenous negative portrait of LGBT aging, presenting his work on gay male aging at the 1972 meeting of the Gerontological Society of America (Kimmel et al., 2006). Kelly's (1977) published study of older gay men used questionnaires, interviews, and participant observation in the Los Angeles gay community concludes that "there is little evidence in this study to suggest that being gay causes problems in old age, but there is a great deal of evidence to suggest that societal stigma causes problems for aging gays" (pp. 331-332). This shift to fault societal stigma and discrimination, rather than the individual gay person, threatened long-standing notions concerning LGBT aging and set a new wave of sexual minority

aging research into motion. Following Kelly's (1977) lead, early studies (Kimmel, 1977; Minnegerode & Adelman, 1978; Berger, 1980; Raphael & Robinson, 1980) suggested that coping with a stigmatized identity in earlier life enhanced older LGBT adults' ability to adjust to old age. Kimmel (1977) approaches his study from a psychotherapy lens, asserting the need for a range of services for elderly gay people, including couple's counselling, bereavement counselling, and peer counselling. He dispels the assumption that older gay men are destined to an unfavourable life in old age, as many older gay people have "displayed an extraordinary capacity for change in their later years, in part because of the recent social changes of gay liberation" (Kimmel, 1977, p. 393). Like Kimmel (1977), Berger (1980) found that the majority of the participants – all of whom were older homosexual men – were well-adjusted and satisfied with their lives, citing a "commitment to homosexuality" as a variable in supporting this satisfaction.

Minnegerode & Adelman (1978) were the first to include lesbian women in empirical research that countered the fatalistic narrative of LGBT aging. In their pilot study, they interviewed older homosexual men and women, finding that homosexuality did, in fact, influence their everyday lives; however, it "enriched" rather than "cramped" their lives (Minnegerode & Adelman, 1978, p. 456). Notably, they found that, unlike the gay male participants, none of the lesbian participants reported experiencing discrimination based on their sexuality; however, they did feel constraints on their occupational careers because they were women (Minnegerode & Adelman, 1978, p. 452). In a later study, Raphael and Robinson (1988) reiterated the profound effect of lesbianism on the lives of older lesbians. Focusing their research solely on lesbians, they found that older lesbians had a unique capacity to adapt to the challenges associated with aging (Raphael and Robinson, 1988). They propose that the influence of

lesbianism is more significant than aging itself and extend this sentiment to other powerful influences such as race, class, and educational background, suggesting that lesbianism is the main determinant in the choices of older lesbians' lives. Raphael and Robinson (1988) suggest that lesbian identity impacts a variety of areas, including, but not limited to, support networks, participation in social activities, usage of professional services, and places frequented. In turn, Raphael and Robinson (1988) state that "once lesbianism is seen to be the most significant factor in understanding the old lesbian's life situation, it becomes apparent that whether a lesbian is in or out of the closet becomes the next significant factor" (p. 69). This recognition of the closet underscores a dichotomy echoed repeatedly in the literature on older lesbians, which contrasts the lives of "long time lesbians" and "late-blooming lesbians" (Gabbay & Wahler, 2002, p. 7). Here, this dichotomy refers to individuals who were aware of, and claimed their lesbian identity in early life (i.e., adolescence or young adulthood), and those who adopt a lesbian identity later in life, frequently after heterosexual marriage and the raising of children (Gabbay & Wahler, 2002; Raphael and Robinson, 1988).

Theorizing Queer Aging

These early empirical works created a foundation for theorizing LGBT aging outside of medicalizing and criminalizing perspectives (see Galanti, 1992; Siegel, 1988). However, there has been a dual silencing of queerness in theories of aging, and silencing of aging in theories of sexuality, which has contributed to a lack of formal theories on LGBT aging (Brown, 2009; Twigg, 2004). Although theories of sexuality have brought a critical analysis of heterosexuality, they have largely overlooked age as a status and a phenomenon (Brown, 2009; Heaphy et al., 2004; Sandberg, 2008; Ramirez Valles, 2016). LGBT studies have ignored a fundamental consideration of aging theories: that cohort, history, and context matter in understanding the

experience of aging. Some social scientists (Bitterman & Hess, 2020; Weststrate et al., 2023) propose that this gap in the literature is due to LGBT communities being historically less intergenerational, as the LGBT community "nearly lost an entire generation" due to the HIV/AIDS epidemic which, by severely reducing the number of LGBT elders, amplified their exclusion from queer and aging theories (Weststrate et al., 2023, p. 3). Others suggest that this gap is a product of gerontology being anecdotally known as politically conservative, as it subscribes to heteronormative theories of aging that are committed to notions of masculinity, the nuclear family, and white middle-class perspectives (Brown, 2009; Ramirez-Valles, 2016). Regardless of the reason, this pervasive dual silencing has resulted in the formation of only two theories of LGBT aging: accelerated aging and crisis competence.

The first theory to describe gay male aging was accelerated aging. Formal theories of LGBT aging were based on the gay male experience and often did not include lesbians until later (Berger, 1982; Ramirez-Valles, 2016; Schope, 2005). Accelerated aging argues that the markers of aging (e.g. functional and health decline) appear earlier in gay men. This may be the particular case for gay men living with HIV/AIDS, whose aging might be "both accelerated and exacerbated because of the virus, medical therapies and their combined side effects" (Ramirez-Valles, 2016, p. 16). For gay men who are not living with HIV/AIDS, the theory of accelerated aging contends that gay men "view themselves as older at a time when heterosexual men do not" (Schope, 2005, p. 25). Citing a youth-focused culture of gay men, Berger (1982) suggests how it is a commonly accepted statement that a gay man is old when he turns 30. Berger (1982) coined the term "youthism" to mark the extreme degree that youth and beauty were overly linked to value within gay male culture. In this sense, the seemingly feared markers of aging are specific to physical appearance rather than functional and health decline.

Contrastingly, accelerated aging is rarely used to describe lesbians, despite also being subject to long-term stigmatization (Gabbay & Wahler, 2002; Heaphy et al., 2004; Schope, 2005). Schope (2005) notes that there is "little or no reference to the existence of age acceleration in the literature on elder lesbians" (p. 27). Similarly, other scholars (Gabbay & Wahler, 2002; Laner, 1997) suggest that lesbians do not experience accelerated aging and, instead, draw attention to how heterosexual women do. In response to this limited literature, Schope (2005) suggests that the privileging of youth is less of a pressure for lesbians than for gay males. This is suggested to be in part due to the contrast of increased ageism in gay male communities (Schope, 2005), but also because "hegemonic notions of manhood revere youthfulness" (Slevin, 2008, p. 38). In turn, social science literature has painted lesbians' experiences of aging under the broad stroke of crisis competence.

During Kimmel's (1978) early empirical work in the field, he coined *crisis competence,* the second prominent theory describing the unique experiences of aging for the LGBT community. Crisis competence – or mastery of crisis (Berger, 1980) – is a unique attribute formed as a result of navigating queerphobia throughout the life course, providing older LGBT adults with skills to cope with the challenges of aging (Bower et al., 2021; Heaphy et al., 2004, 2007; MetLife & American Society on Aging, 2010). It may develop from experiences of healthcare discrimination, family rejection, or "by virtue of being LGB" (Caceres & Frank, 2016, p. 189), referring to the necessary adaptation LGBT people must embody to survive within our hostile, heteronormative society. For example, in the MetLife and American Society on Aging's (2010) study with 1,000 self-identified LGBT people aged 40-61, survey and interview data showed that three-quarters of participants found that their sexual orientation helped prepare them for aging, with 29% stating that coping with discrimination, in particular, provided them with

skills to prepare for the challenges associated with aging. This is not to suggest that older LGBT are without problems in older age, but rather, to describe a unique translation of skills developed through navigating queerphobia over the life course to the experience of aging.

In exploring the hypothesis of crisis competence, some scholars (Almvig, 1982; Kehoe, 1986; Novak et al., 2018) emphasize lesbians as being particularly skilled in this crisis competence. For example, Almvig's (1982) early work found that an older lesbian's relationship with mainstream (i.e. heterosexual) culture is generally one of coping. Nearly three-quarters of participants in Almvig's (1982) study reported that their lesbianism had been a source of great joy and satisfaction, with over 65% of participants stating they felt positively about their aging. This positive conceptualization of aging had a domino effect that allowed participants to better cope with stressors, such as those associated with aging, and led to an increased sense of independence (Almvig, 1982). Kehoe (1986) attributes lesbians' unique acquisition of crisis competence to older lesbians being a "triply invisible minority" – as women, as old, and as sexually "deviant" (p. 139). In turn, Kehoe (1986) suggests that lesbians in later life are "survivors" (p. 139) and, by extension, have acquired coping skills that allow them to better manage the challenges associated with aging.

Queer Life Events

In recent social science literature, theories of LGBT aging are rarely used independently; instead, they act as variables embedded within a more holistic discussion of the queer life course (Fabbre et al., 2019; Stinchcombe et al., 2021). As part of this more comprehensive approach to understanding the lives of LGBT people, a prominent theme has emerged; LGBT people consistently report distinct life events rarely examined in traditional (i.e., heteronormative) gerontological research (Fredriksen-Goldsen et al., 2015, 2017; Fredriksen-Goldsen & Muraco,

2010; Goldsen, 2018; Westwood, 2015; Wilson et al., 2021). These life events typically center around sexual and gender identity development, unique kin relations, and the historical marginalization in social institutions like work and education (Fredriksen-Goldsen et al., 2015, 2017). For example, Heaphy et al. (2004), like other scholars (Dorfman et al., 1995; Pugh, 2002), highlight the "relational and community contexts in which individuals age" as being key contributors to LGBT people's experiences throughout the life course (p. 882). In a North American study of 180 heterosexual and homosexual older adults, Dorfman et al. (1995) found that the most significant difference between these groups was that the latter relied more on friendship families or "families of choice" (Weston, 1997) for support (Heaphy et al., 2004).

In terms of sexual and gender identity development, social science scholars suggest that "coming out" is an important life event for 2SLGBTQIA+ people (D'Augelli et al., 2010; Fredriksen-Goldsen, 2017; Goldsen, 2018). In their study with 2,450 LGBT adults aged 50+ in the United States, Fredriksen-Goldsen et al. (2017) found that the average age of first awareness of LGBT+ identity amongst participants was about 21, with the average age of first identity disclosure around age 28. This time from first awareness to first disclosure suggests a common practice of waiting – in this case, for seven years (on average) – before coming out or openly disclosing their identities (Fredriksen-Goldsen, 2017). This "waiting time" is highly variable, and scholars have attributed this age of awareness and disclosure to generational differences, specifically the historical and social contexts that the age cohort grew up in (D'Augelli et al., 2010; Fredriksen-Goldsen, 2017; Goldsen, 2018). For example, D'Augelli et al. (2010) found that the average age of coming out among their 196 youth participants was age 14. Further, trends in coming out experiences differ amongst members of the LGBT population. Unlike gay men, many older lesbians first self-identify as a sexual minority later in life and as previously

mentioned, are more likely to have been in an opposite-sex marriage earlier in life, which may also increase their likelihood of having children (Fredriksen-Goldsen, 2017). Regardless of LGBT identity, Goldsen (2018) suggests that coming out later in life is also associated with later involvement in LGBT communities and activism, "which serve as important experiences for developing a sense of purpose and belonging" (p. 24). Recognizing these differences as a part of understanding the queer life course is key to understanding the effects they have on individual's lives as they age.

Queer-specific life events have a unique influence on the health and well-being of 2SLGBTQIA+ older adults (Fredriksen-Goldsen, 2017). To understand their impact, social scientists (for example, Brotman et al., 2015; Fredriksen-Goldsen, 2016; Fredriksen-Goldsen et al., 2017; Stinchcombe et al., 2021) often employ minority stress theory. This theory was initially developed to describe the unique barriers for gay men (Meyer, 1995) and then expanded to include lesbians and bisexual people (Meyer, 2003). Minority stress theory is based on the premise that "gay people in a heterosexist society are subjected to chronic stress related to their stigmatization" (Meyer, 1995, p. 38). Minority stressors can include internalized homophobia and lived experiences of discrimination and violence (Meyer, 1995, 2003). In the context of health and well-being, 2SLGBTQIA+ older adults,[6] when compared to cisgender heterosexual older adults, showed significantly higher likelihoods of chronic health conditions, including low back or neck pain, weakened immune systems, and disabilities (Fredriksen-Goldsen et al., 2011, 2017).

[6] While outside the scope of this study, it is important to note that physical and mental health disparities are more prevalent among gender-diverse populations than their cisgender LGB counterparts (Cook-Daniels, 2006; Fabbre, 2014).

These health disparities vary across different generations of 2LGBTQIA+ people. Fredriksen-Goldsen (2016) suggests that there are three generational divides amongst LGBT older adults, namely: the Invisible Generation (1929-1939)[7], the Silent Generation (1940s-1950s), and the Pride Generation (1960s-1970s). The Invisible Generation experienced the Great Depression, and many fought in WWII—"at which time LGBT identities were largely absent from public discourse" (Fredriksen-Goldsen, 2016, p. 8). Comparatively, the Silent Generation came of age against the backdrop of the McCarthy trials and the Lavender Scare (Fredriksen-Goldsen, 2016). During this time, same-sex behaviours, typically characterized as "sodomy," were criminal, and the American Psychiatric Association had classified homosexuality as a psychiatric disorder (Fredriksen-Goldsen, 2016, p. 8). Lastly, the Pride Generation came of age at a time of tremendous social change, as evidenced by the Stonewall riots (1969) and other social and civil rights movements. Fredriksen-Goldsen (2016) asserts that:

> While LGBT adults from the Invisible and Silent generations report higher degrees of internalized stigma and identity concealment, they are individually less likely to have experienced discrimination and victimization, suggesting identity concealment may be protective in hostile environments. Conversely, for those of the Pride Generation, internalized stigma and identity concealment are lower, but discrimination and victimization are higher, as are loneliness and social isolation. (p. 8)

The health disparities and unique life events (i.e., kinship relations, experiences of coming out) experienced by LGBT and Queer older adults provide insight into their needs in later life. In Stinchcombe et al.'s (2021) qualitative study with ten focus groups in ten cities across Canada, they found that 2SLGBTQIA+ older adults are less likely to have children, more likely to be single, and are more likely to rely on fictive kin. In turn, participants expressed

[7] Please note that the dates in brackets for each of these generations signify when members of the generation "came of age" (Fredriksen-Goldsen, 2016), or in other words, when they "grew up" – signalling a transition from being a youth to a young adult.

worry about who would be there to support them in old age (Stinchcombe et al., 2021). As LGBT adults age and experience increasing care needs, scholars assert that they will not access healthcare services because of traumatic lived experiences and a fear of discrimination and victimization (Brotman, 2015; Fredriksen-Goldsen, 2016; Novak et al., 2018; Stinchcombe et al., 2021). In response to this societal homophobia, and the Canadian healthcare system being one of the "primary arenas that exerted control" over them, LGBT older adults may choose to hide their LGBT identity when seeking out health services (Brotman et al., 2003, p. 192; Fredriksen-Goldsen, 2016; Stinchcombe et al., 2021). While this identity concealment is employed strategically in hopes of avoiding queerphobia, it maintains their invisibility and marginalization within the health and social care services. Identity concealment, alongside the silencing of LGBT adults through their mutual exclusion in theories of sexuality and aging, has left LGBT seniors without adequate social or material support (Brown, 2009; Cahill, 2002). This has meant that LGBT older adults have been long alienated from both the LGBT and older adult community, as well as the human services agencies serving those communities, like later-life housing services (Cahill & South, 2002; Cook-Daniels, 1997).

For my thesis, I retain minority stress and crisis competence as relevant theories for answering my research questions. Minority stress is the most relevant for my study since I aim to explore the influences of participants' sexuality on experiences of later-life housing. Therefore, by identifying LGBT-specific experiences in later-life housing, I will also be identifying instances of minority stress. Likewise, by coping with minority stress, LGBT and Queer older adults tend to acquire crisis competence. As a unique attribute that provides older LGBT adults with skills to cope with the challenges of aging, I argue that crisis competence inherently influences older LGBT and Queer older adults' experiences of later-life housing.

Considerations for Later-Life Housing

Like all older adults, LGBT people are likely to consider a housing transition in later life. These transitions are often catalyzed by many of the same factors as non-LGBT adults, such as an increased need for care provision. However, when considering these house transitions, LGBT and Queer older adults must contend with potential housing discrimination based on their gender and sexual minority status (Putney et al., 2021; Redden et al., 2023; Thomas et al., 2023). Older adults fear discrimination from other residents in congregate living settings, as "older non-LGBT residents grew up at a time when discriminatory views about LGBT people were the norm" (Redden et al., 2023, p. 120). Likewise, older adults also express fear about discrimination from staff in congregate living options as they are likely to interact with them on a daily basis, and in the case of long-term care facilities, they are the individuals providing nursing and personal care, meaning they have considerable opportunity to incite violence against LGBT residents (Pijpers & Honsbeek, 2023; Putney et al., 2018; Willis et al., 2016). These fears are particularly heightened in late life, as older adults become concerned with their decreased ability to advocate for inclusive care for themselves (Kortes-Miller et al., 2018; Stinchcombe et al., 2021; Wilson et al., 2018). This fear of decreased ability to advocate for themself is exacerbated by a fear of an impending breakdown of support, given that LGBT and Queer individuals may be less likely to have children

A recent scoping review by Torelli et al. (2023) indicates that 2SLGBTQIA+ people represent one of the groups most likely to depend on formal care services because of their socio-economic vulnerability. This lifelong experience of discrimination has meant that LGBT adults are more likely to live alone, not have children (who could provide care in the face of increased care needs), be unsupported or estranged from their family of origin, and live in poverty

(Fredriksen-Goldsen, 2017; Goldsen, 2018; Redden et al., 2023; Redman, 2012; Stinchcombe et al., 2021 Torelli et al., 2023, Westwood 2016). Despite LGBT and Queer adults being amongst the most likely to require formal care services, most social science literature on discrimination against LGBT people in housing settings is specific to these care contexts. In turn, LGBT and Queer adults' risk being subject to a distinct "double trauma" as they adapt to communal living and become "coupled with anxieties about being obliged to conceal differences in gender identity and sexual orientation" (Willis et al., 2018, p. 2; Westwood, 2016; Wilson et al., 2018, p. 2).

For older LGBT and Queer people, residing in an LTC facility corresponds to living in an environment in which heterosexuality is generally presupposed, meaning "it is an environment that does not offer security to live with friends and life partners without situations of vulnerability and violence" (Torelli et al., 2023, p. 3130). Fears about later-life housing have sparked discussion about LGBT-designated housing amongst social scientists (Almvig, 1982; Pang & Maclennan, 2023; Redden et al., 2023; Torelli et al., 2023). This desire for LGBT-specific housing is not new for older LGBT adults, as evidenced by Almvig's (1982) qualitative study with older lesbians. In this study, the majority of participants indicated an interest in a gay-oriented retirement community and, if inevitable, gay-affirmative nursing home facilities (Almvig, 1982). Moreover, a study conducted by Johnson et al. (2005) in Washington state, US, found that an overwhelming majority (98%) of their 127 respondents (56 gay men, 60 lesbians, nine bisexuals and two transgender people) believed that 'LGB-specific' or at least 'LGB-friendly' housing would be preferable. Despite clear desires for these inclusive care home models, there is only one example of its implementation in Canada. In 2022, the Rekai Centres in Toronto opened a 25-bed wing for 2SLGBTQIA+ residents within one of its existing care homes that houses 150 residents (Jabakhanji, 2022). While this wing is certainly aligned with the

desires for LGBT-specific or at least LGBT-friendly housing, it does not absolve the fears and experiences of discrimination held by older 2SLGBTQIA+ adults across the country.

Acknowledging these fears and experiences of queerphobia, long-term care facilities have implemented strategies to support LGBT inclusivity. These strategies include LGBT-themed programming, adopting inclusive, gender-neutral language and symbols, and, most commonly, developing and implementing an anti-discrimination policy (Hafford-Letchfield et al., 2018; Pijpers & Honsbeek, 2023; Torelli et al., 2023). While these anti-discrimination policies and practices are typically non-specific to LGBT people, they take a broader approach to promoting inclusivity and respect for diversity and, in turn, allow for LGBT-specific interventions. These interventions are often in the form of LGBT inclusivity training for staff, as formal schooling improperly addresses the health and care needs of 2SLGBTQIA+ people (Sussman et al., 2018; Torelli et al., 2023). In addition to providing staff with education about the unique needs of LGBT and Queer residents, this training is critical for countering staff beliefs, as many LTC staff believe that the history of homophobia is "now a thing of the past" (Torelli et al., 2023, p. 3126). In turn, these training opportunities can provide staff with the knowledge and skills to provide individualized and informed care that recognizes the needs and lived experiences of LGBT residents.

While these staff training, and other inclusion strategies, such as LGBT-specific programming and displaying pride symbols in long-term care facilities, have shown to have a considerable impact on improving the experiences of older LGBT and Queer residents (Hafford-Letchfield et al., 2018; Pang & Maclennan, 2023; Pijpers & Honsbeek, 2023; Sussman et al., 2018), it must be stated that adopting these strategies is not a "one size fits all" approach. These inclusion strategies are based on generalized – and, at times, performative – ideas of LGBT

inclusion and do not account for the heterogeneity of older 2SLGBTQIA+ adults. For example, some 2SLGBTQIA+ fear that queer-specific housing may worsen their social isolation, as they will be segregated from non-LGBT people and, in turn, limit opportunities to promote acceptance (Thomas et al., 2023). Likewise, strategies of visibility, such as displaying pride-related symbols around the facility and offering LGBT-specific programming, may reinforce "hierarchies of difference" which maintain "othering ideas about sexual difference" (Willis, 2017, p. 116) that become anti-thetical to the goals of these strategies. For example, if a LTCF displays images of same-sex couples to help promote visibility, it is likely that these photos will be of white cisgender people. Displaying images of same-sex couples also "cloaks bisexual identities and biographies from view" (Willis, 2017, p. 117). While the goal of this strategy is to promote visibility, it is inadvertently excluding members of the 2SLGBTQIA+ community. In turn, the approaches to improving the lives of older LGBT and Queer adults in later-life housing must reflect the heterogeneity of their needs and the unique cultural context that shapes their lived experience (Westwood, 2015; Willis, 2017).

This Study

With this context in mind, this thesis seeks to understand the experiences of LGBT people living in later-life housing facilities and how they can be better supported in their place of residence. To do this, I combine elements from theories of aging (i.e., age cohorts and the life course perspective) with theories of queer aging (i.e., crisis competence and minority stress) to understand participant's experiences. In turn, this thesis fills a gap in existing social science literature by addressing the experiences of older LGBT adults across the later-life housing continuum, namely independent living and long-term care facilities. As previously mentioned, the few studies that are focused on LGBT older adults' experiences of later-life housing are

primarily concerned with LGBT older adults who are residing independently in their homes and report their fears about entering into congregate living settings – often, long-term care facilities, specifically (Furlotte et al., 2016; Savage & Barringer, 2023; Westwood, 2015; Wilson et al., 2018) – or focus on long-term care home staff and administrators' interpretations of LGBT and Queer resident's experiences of long-term care (Kortes-Miller et al., 2018; Sussman et al., 2018). In turn, this thesis offers insights into strategies for LGBT inclusion that are informed by participant's lived experiences. As Willis (2017) suggests, the voices of LGBT adults living in care environments must be heard "to be able to fully understand the ways in which visibility strategies can be received and experienced" (p. 118). Further, this thesis adds to the extremely limited literature on older lesbian, bisexual, and Two-Spirit women's experiences in later-life housing and provides visibility to some of the unique experiences of LGBT and Queer older adults in Atlantic Canada[8]. This study is guided by two questions: *How do older LGBT adults describe their experience transitioning into and living in later-life housing facilities (i.e., independent living, assisted living, and long-term care), and how, specifically, do they describe their sexual identity as influencing these experiences?* Second, *How can residential facilities better support LGBT and Queer residents?*

[8] The term Atlantic Canada refers to a region of the east coast of Canada that includes New Brunswick, Prince Edward Island, Nova Scotia, and Newfoundland and Labrador. This region is often assumed to be politically conservative. However, this sweeping assumption is likely due to its rurality and being "economically depressed" rather than political events, "as polls over the past few years suggest this region has the most progressive views on immigration and socio-cultural diversity in Canada" (McLay & Ramos, 2021, p. 3; Lewis, 2015).

CHAPTER THREE: METHODS

The purpose of this study is to understand the experiences of LGBT people living in later-life housing facilities, how their experiences are influenced by their sexual identities, and how they can be better supported in their place of residence. To do this, I employed the following qualitative research methods: setting up and running a gay-straight alliance group, doing observation in and around the group sessions, and conducting semi-structured interviews. This research design was approved by the Dalhousie Research Ethics Board (file #2023-6724) on November 28th, 2023, and by the long-term care facility on January 4th, 2024. The long-term facilities in this thesis are not named to maintain anonymity, as per my research ethics protocol. The following chapter will discuss chronological methodological considerations, including site selection, recruitment, research methods, relevant participant information, data analysis, and ethical considerations.

Site Selection and Recruitment

Continuing care encompasses care services and organizations provided to people outside of the hospital. The continuing care organization included in this study offers various continuing care services across the continuum of later-life housing, from private home care to long-term care. As a result, in this thesis, continuing care is used as an umbrella term that encompasses independent living, assisted living, and long-term care. This continuing care organization was selected as the site for this research for a variety of reasons, including the large size of its facilities and its commitment to equity, diversity, and inclusion, which is displayed on their website and all social media platforms. The size of the facilities was important as it provided the greatest opportunity to recruit LGBT and Queer older adults for my study. Moreover, the continuing care organization's commitment to equity, diversity, and inclusion was important

since I wanted, and frankly required, support from the organization to conduct my research. I first made contact with the facility's research coordinator, who also sits on the facility's internal ethics board. In this first email to the research coordinator, I described the project, its rationale for understanding how long-term care homes can provide life-affirming care to LGBT people, and the proposed methods to gauge the facility's interest in participating in the study. The research coordinator confirmed interest in the research, citing their commitment to supporting the LGBT community and their collaboration on previous LGBT-centered research projects.

For context, the inclusion criteria for this study were, initially, to identify as a part of the LGBT community and to be a resident at the specified long-term care facility. Prospective participants did not need to attend the weekly gay-straight alliance to participate in an interview. However, after over a month of recruitment at the selected site, I was not contacted by any prospective participants. Given the project's shortening timeline, I submitted an amendment request to the Dalhousie REB to add three additional sites under the same organizational management. Once accepted by Dalhousie's REB and the LTCF, this amendment broadened the inclusion criteria to allow anyone who identified as LGBT+ and lived in any of the following organization's accommodations: two independent living campuses (90+ units) and two long-term care facilities (500+ beds). Recruitment methods for the additional buildings followed the same protocol as the initial site, with the exception of not recruiting from a facility's gay-straight alliance group. Due to time constraints, the gay-straight alliance group was only offered at the initial building, and the group continued to run weekly as initially planned.

Recruitment of participants from the long-term care facility began following the initial approval of the research ethics protocol, and recruitment efforts in the additional three sites began immediately following the approval of the amendment request. Recruitment efforts

included postering around the facility at sightlines for both ambulatory residents and wheelchair users. These posters were placed on each floor's small communal bulletin board, in each building, and in elevators when permitted. A digital poster was shown on screens located around the building's main areas, which are used to communicate relevant information to residents about the facilities' services, scheduled maintenance work, recreational activities, and research projects. These recruitment posters included information about myself, the project, and information about the gay-straight alliance group – including the time, place, and offer of refreshments.

My position as a sexual minority "insider" was clearly stated on recruitment posters. However, I intentionally labelled myself as a lesbian on these posters as I was hesitant to include my identity as Queer, despite this being the term I would typically use to describe myself. This decision was made in recognition of the contested reclamation of the word Queer, as I did not want to create discomfort for prospective participants, and I still felt that the term lesbian was still representative of my identity. Similarly, recruitment posters intentionally used the language of "LGBT & Queer" when speaking to inclusion criteria. I intentionally separated the acronym from Queer with an ampersand, rather than stating "LGBTQ," in an attempt to recognize the contested nature of the term and its separation from the "traditional" acronym. The term Queer was included to signal the inclusion of anyone who falls under the larger 2S/LGBTQIA+ acronym and to recognize that there may be young adult residents in long-term care who feel more aligned with the term "Queer."

In addition to postering, part of my recruitment strategy was speaking with staff and residents. To begin, I spoke with residents who were in public areas of the building, administrative staff at the front desk and the nursing staff on each floor to let them know about

the study, its inclusion criteria, and, for the LTCF included in my first protocol, the gay-straight alliance group. Each week I visited the facility for the gay-straight alliance group, I would speak with residents, admin staff, and nursing staff about the project to ensure that staff and residents knew that the project was still ongoing, and to field questions as they arose. As per the standard recruitment process for research projects at the facility, the staff members would approach prospective participants, provide them with information regarding the research study, and assess their level of interest. With permission from potential participants, their names and contact information would be provided to the researcher, who would then follow up with the prospective participant independently.

After some of these early conversations with staff, I was approached by the volunteer coordinator, who shared that she thought the project was important. She asked for a recruitment poster, which she used to tell residents about the study and the gay-straight alliance group. After approximately a month of recruitment efforts, I was approached by a senior social worker. He asked to set up a meeting so that I could provide details about the study to his team of social workers. Like the volunteer coordinator, he expressed the value he saw in the study. I met with the team of social workers and provided them with consent forms that they could distribute to prospective participants who were interested in receiving more information about the project. During this meeting, each of the social workers recalled residents who identified as LGBT; however, they all stated that these individuals were only "out" to select people and that they would likely be unwilling to participate. Despite this, the team of social workers agreed to help spread the word to residents.

Research Methods

Gay-Straight Alliance Group

Following the initial research ethics approval from the long-term care facility, I established a resident-led gay-straight alliance (GSA) group. Initially intended to be a form of participatory action research (PAR), the goal of the GSA was to create a shared safe space for residents to engage in conversation with each other, recruit prospective participants, and act as a site of observation. The GSA's first meeting was on January 26th, 2024, and it ran weekly until March 29th, 2024. Each meeting took place in a large meeting room on the ground floor of the main building. This location was selected because it was accessible by both the elevator and the stairs, had a wheelchair-accessible entrance, and, despite being on the ground floor, was hidden from the main social areas in the building. Each week, one self-identified ally attended, and the occasional staff or resident would stop by to engage in conversation. While the turnout was disappointing from a planning perspective, it was also perplexing because of the strong desire for this program by staff, specifically because they anticipated LGBT and Queer residents would appreciate having a designated space and, in turn, would attend. The lack of attendance at the group changed the research design, which sparked the amendment request,

Observation occurred weekly at the GSA group, and data was collected using an observation note guide. I intentionally did not record any observation notes during the GSA in order to evade concerns surrounding surveillance. Instead, I wrote reflexive notes that described observations about events in the gay-straight alliance group and around the LTC facility. I carried out weekly observation during the gay-straight alliance over the course of 11 weeks. With the lack of participants in the GSA, aside from the self-identified ally, observation notes capture more broad observations about the facility and, on some occasions, include descriptions

of interactions with staff and other residents who interacted with the GSA group (e.g., encouraging residents to attend, stopping in to state their support) but did not attend.

Semi-Structured Interviewing

Since the GSA did not happen as planned, I had to pivot recruitment efforts. I spoke with the facility's research coordinator about further recruitment opportunities and explained the unexpected non-attendance of the GSA. From this meeting, the research coordinator and I decided to include the recruitment poster on the facility's social media page (I refrain from mentioning which social media platform to protect anonymity). I was contacted by email by three participants as part of one larger email thread. The first email included two participants (Vera and Ruth), who were a couple, and after I responded, they looped in their neighbour (Mary). These three participants are residents of the independent living facility and had seen the social media posts. They expressed excitement about participating, and I interviewed all three of them – separately, in their respective apartments – later that week. With a rejuvenated hope for recruitment and having learned about the experiences of older LGBT adults from these interviews, I was determined to recruit participants from the long-term care facilities.

The next week, when I arrived at the long-term care facility, one of the staff indicated that they were speaking to a resident (Violet) who may be interested in the research; however, she wanted to meet me beforehand. The resident had told the staff they were happy to meet me in one of the shared spaces of the facilities, and I waited there to speak with her. She then met me in this location, we spoke about the research project, my experiences as a Queer person, and my plans for this research. After this conversation, she agreed to participate, and we scheduled her interview for the following week. The final two participants – Clara and Alice – reached out to me by phone after completing Violet's interview. They did not mention the recruitment posters,

but rather that they were simply interested in participating, which leads me to believe that the fourth participant shared information about the study with other residents at the facility. These final two interviews were conducted on March 22nd and 23rd. These three interviews were conducted in the residents' respective rooms.

Using an interview guide (Appendix A), I asked about participants' experiences moving into and residing at their place of residence, how they understand the role of their sexuality in navigating this transition, and how they could be better supported. Additionally, I asked participants to discuss their 2SLGBTQIA+ identity and the language they use to describe themselves to ensure they were represented and referred to accurately in the project. Using semi-structured interviews allowed participants to give subjective descriptions and explanations of "why things are and should be how they are, or why they should be different in a certain way" (Diefenbach, 2009, p. 890). Participants' justifications and explanations illustrated their personal beliefs and values, often in relation to their generational cohort, and by extension, provided additional insight into the self-imagined influence of their sexuality in their experiences in LTC.

As seen in the table below, I had six participants participate in a semi-structured interview – three who lived in independent living and three who lived in assisted living. During interviews, participants were prompted to select a pseudonym that would be used to de-identify their interview data. If a participant did not want to choose their own pseudonym, I assigned them one. On average, interviews lasted a duration of 55 minutes. While six participants may be considered a small sample size, these qualitative interviews generated a wealth of data. Interviews were transcribed, coded, and thematically analyzed using Braun and Clarke's six-phase analytic method (2006). More specifically, thematic structures were achieved by a) gaining familiarity with the transcripts, b) generating initial codes, c) grouping and regrouping of

codes, d) searching for identified themes, e) organizing a thematic map to review, and f) defining themes (Braun & Clarke, 2006). From this analysis, the following five themes emerged from the interview data: (1) Generational context, (2) Preparing to move, (3) Building relationships, (4) Managing LGBT identity and lastly, (5) Considerations for future housing.

Participants

Table 1

Interview Participants

Participant	Age	Identity	Housing Arrangement	Interview Duration
Vera	64	Lesbian	Independent Living	54 minutes
Ruth	63	Lesbian	Independent Living	54 minutes
Mary	62	Two-Spirit, Lesbian	Independent Living	1 hour, 9 minutes
Alice	81	Lesbian	Assisted Living	1 hour
Clara	80	Lesbian	Assisted Living	45 minutes
Violet	75	Bisexual	Assisted Living	49 minutes

I recognize that my sample size may require some justification, despite the breadth of data collected from resident interviews. Fredriksen-Goldsen & Kim (2017) state that recruitment is a primary concern in LGBT aging research, as this population is largely invisible and historically marginalized. Moreover, they describe that it is unfeasible to obtain sufficient samples of smaller subgroups of demographically diverse LGBT older adults using probability sampling (Fredriksen-Goldsen & Kim, 2017). Heaphy et al. (2004) reiterate this sentiment by

stating how a representative sample in LGBT aging research "is impossible" because the LGBT "older adults are hidden, and sometimes closeted, which becomes a barrier when research is relying on self-selection" (p. 883).

This barrier was confirmed by a local older LGBT activist anecdotally, who was the chair of an older LGBT adult community group. After about a month of recruitment efforts, I received a call from this person who said they had been sent a picture of one of my recruitment posters in the long-term care home. Once I confirmed that these were my posters, he jokingly said, "Let me guess, no one has come to your gay-straight alliance." He said that he loved the idea of the GSA, but he anticipated no one would attend. In his role with the community group, he has been trying to recruit residents of the facility to join the local group, or to at least attend events hosted by the group, for ten years. However, no one has ever come – at least openly – from this care home. These challenges were also experienced in Green's (2016) MA thesis from MSVU, which explored the experiences of LGBT individuals living in long-term care in Nova Scotia, had six participants: two LGBT older adults, two older LGBT activists, and two LTC workers (p. 54). Green (2016) recruited from multiple LTC facilities across Nova Scotia and initially aimed to recruit six to eight LGBT residents, yet due to difficulties with recruitment, had to expand inclusion criteria to include stakeholders (i.e., older LGBT activists and LTC workers). Even with these expanded criteria, Green (2016) was only able to recruit six participants in total, two of whom were LGBT residents.

With this rationale in mind, I recognize that this is a small sample size, as I had planned on interviewing 15 to 20 people. However, I am very thankful for the six participants I did receive, considering the barriers that others have encountered. In recognition of this, I want to state that this data is not being used to make firm conclusions about LGBT older adults'

experiences in later-life housing. Instead, this thesis can be understood as a case study of residents' experiences within an Atlantic Canadian continuing care organization's housing.

Ethical Considerations

This study raised various ethical considerations, which I addressed formally through the frameworks of Dalhousie University's Research Ethics guidelines on research involving humans and the long-term care facilities' internal research ethics procedures. One ethical concern I had was about participants feeling some discomfort recounting instances of homophobia over their life course. In recognition that this may incite emotional reactions, I ensured that participants were informed, using the consent form and by outright telling them, about the voluntary nature of their participation, which meant that they could stop their participation at any time. As part of this, I verbally reiterated that participants could skip any questions they would like. Further, I reminded participants they could request a copy of their transcript to review, and that they could withdraw their data from the study before the date indicated on the consent form, both before the interview began and after the interview was complete.

A second ethical consideration I had was about participants' concerns about being identified in my study, especially considering that as part of the researcher agreement with the LTCF, results will be shared in a two-page summary format with the research coordinator, who will then share this summary with additional staff. To mitigate this concern, I ensured that the process for de-identifying data (i.e., using pseudonyms for participant's names, and altering or removing all identifying information such as community names, job titles, etc.) was made clear in the consent form, and I verbally walked the participant through the process of de-identification before beginning the interview. Further, when participants received their transcripts, I clearly indicated where information had been de-identified, and asked if they were comfortable with the

level of de-identification. In one instance, a participant asked me to de-identify part of their transcript further by removing the religious affiliation of the person she was talking about, since she felt that it could be an identifier. I happily agreed to further de-identify this piece of the participant's transcript and sent it back for her approval, which she immediately gave. As stated, I am required to provide a two-page summary to the research coordinator, who will then share the results with additional staff. To protect the anonymity of participants within the continuing care organization, group-level results versus individual results will be shared in the two-page summary, as well as the completed thesis.

Another ethical concern I had was regarding the potential for discovering sub-standard treatment of residents at housing facilities during the research process. Relatedly, I was also mindful that suicide risk is highest in later life (Mezuk et al., 2014), and with comparatively greater feelings of loneliness and depression among long-term care residents than their non-institutionalized counterparts, there may be an increased risk for suicidal ideation amongst prospective participants (Gleeson et al., 2019). To address these ethical concerns, I clearly stated verbally and in my written consent form that any disclosure that entails abuse, neglect or harm to oneself or others will have to be reported to the appropriate contacts. In addition, prior to conducting interviews, I verbally stated that if participants disclose suicidal ideation, I am required to report this to the appropriate authorities.

CHAPTER FOUR: FINDINGS

Moving to and Living in Long-term Care Facilities

After completing a thematic analysis of participant interviews, I identified the following five themes: (1) Generational context, (2) Preparing to move, (3) Building relationships, (4) Managing LGBT identity and lastly, (5) Considerations for future housing. While the first theme may feel separate from the topic of later-life housing, it is important to understand participants' experiences within the historical and social contexts that influenced their life and housing trajectories, in line with the life course perspective (Elder, 1975, 1988; Novak et al., 2018). As stated in chapter one, the "relational and community contexts in which individuals age" are key contributors to LGBT people's experiences throughout the life course (Heaphy et al., 2004, p. 882). By providing insight into these contexts, participants' experiences of later-life housing – and older adulthood – can be understood as both a unique life event, and as the cumulative product of earlier experiences in life. This section begins by setting the scene of interviews to help familiarize the reader with the participants and their homes as much as possible while maintaining anonymity. Then, I discuss each of these five themes, using participants' quotes to describe and provide evidence for these emergent themes.

Setting the Scene

As previously stated, the first three interviews with Vera, Ruth, and Mary took place in their apartments at an independent living facility. From the outside, their building looked like any other apartment building—it was multiple stories high, pale in colour, and had a long concrete pathway to the entrance. I followed this pathway from the parking lot to the large glass doors of the building, holding a variety of baked goods I bought from a neighbouring store to gift participants as a token of my appreciation. When I entered the lobby, Vera was waiting for me,

like she said she would. There were a few other people in the lobby, who I presumed were other residents. I paused for a moment before walking up to Vera, who was talking to a staff member at the time and hadn't seen me enter the lobby. There were other older women in the lobby; however, Vera presented as what I would consider the stereotype for an older, 'masculine'[9] lesbian. She had very short hair, was wearing a plaid shirt, and had small black hoop earrings – which, as I got closer, had small rainbows on them, providing me with a sense of confirmation that this person was, in fact, Vera. Once Vera finished her conversation with the staff member, I approached her and said, "I think you're who I am looking for. My name is Hannah." To which she replied, "You're right. How did you know it was me?" I responded by telling her it was "just a feeling I had, and my radar was going off," playing on a common LGBT joke of having a "gaydar." She chuckled in response and confirmed that my gaydar was "working well."

Vera led me to her and her partner Ruth's apartment. As we walked through the building, I noticed numerous signs about recreational activities and social programming being offered at the building. We walked down a long, narrow corridor and entered the apartment. It was a small two-bedroom apartment with a large window in the living room and a cat tree centered in the middle of the room. After some warm conversation and a cup of tea, Ruth went to visit Mary so I could begin interviewing Vera. While I offered to interview them together, the pair chuckled and said they wanted to be interviewed separately; otherwise, Ruth "would take over the interview." I interviewed both Vera and Ruth in their living room. I sat on their couch while they sat on a loveseat beside me. Following the interview with Ruth, I was lucky enough to have a tour of

[9] While masculine wouldn't be my preferred word choice, I do not want to label participants with language they did not explicitly use to describe themselves. For example, in this case, I feel inclined to use the word "butch" to describe Vera's (and Ruth's) physical appearance; however, this term has associated traits outside of a lesbian's physical presentation, which I do not know if my participants identify with.

their spare room, where they keep a large box with photos they have together. Ruth showed me several pictures of her and Vera when they were in their early 20s and were still closeted.

Following my interview with Ruth, Vera came back to their apartment, and they led me to Mary's apartment. Like Vera and Ruth's apartment, Mary had a large window and cat tree in her living room. Mary's apartment was a small bachelor, and her "bedroom" was located in a small nook off her living room. In between this nook and her living room was her home office. She joked that "it might be small, but it's everything you could need." Mary's home was decorated with family pictures and her beadwork. Like my interviews with Vera and Ruth, I sat on the couch, and Mary sat on a loveseat beside me.

As previously mentioned, the next three interviews occurred in residents' rooms at the long-term care facility, which is in a city different from the independent living facility Vera, Ruth, and Mary live in. The LTCF is a similar pale colour to the independent living facility but is exponentially larger in size. The LTCF's exterior is covered in small windows to residents' rooms. To help set the scene for Clara, Alice, and Violet's interviews inside the LTCF, I will begin with an excerpt from my notes from the first day of the GSA that describes some of my observations about the facility:

> "*Walking through this building feels like a labyrinth. One of the residents noticed I was lost, likely from the disgruntled look and sweat on my face, and told me "don't worry dear, I get lost too. But I'm a bit older than you." I had to ask a volunteer to help me get to the GSA room because of all the twists and turns and hallways and elevators. I am sure I will get used to it. What I don't think I'll ever get used to is how hot it is here. I am never wearing this winter jacket again. The air is hot and stuffy. I joked with a resident as I passed through the sunroom (a seemingly popular spot for residents to socialize) that I feel like I am on vacation with how warm it is in here and that I wish I could crack a window. He responded, "they took away the handles to open the windows." While I figure this is likely a safety precaution, it was a rather sobering comment for me at the time…"* (Observation notes, January 26th, 2024)

My first interview was with Violet. I travelled to her room using the famously busy elevators; as I walked down the long, narrow hallway, I noticed the set of doors on both sides of the hallway. Some people had theirs decorated with a doormat, some with a sign on the door, others had a small nook beside their door that was overflowing with what I assumed was mail, and some had nothing at all. I knocked on Violet's door upon arriving, as she had instructed me to do after our meeting the previous week. She told me to come in, and I entered her room. It was very small in size – it reminded me of my old residence room. Her room had a medium-sized window that she had decorated with a few colourful suncatchers and trinkets. She apologized for the "mess" and explained that she often has low energy and that she didn't want to use the limited energy she had on cleaning. I assured her that all was well and that my room is often very messy, so there was no judgment at all. She asked if she could stay seated on the bed for the interview, and I told her that her comfort was the utmost priority. She then proceeded to lie down on the bed and said, "how about this?" I giggled and said, "even better." She laid on her bed for most of the interview while I sat in a chair that was by her desk. After the interview, she thanked me for coming and said that it was nice for someone to "show interest" in her life, especially the parts she "doesn't always get to talk about."

The second interview was with Clara. In her hallway, people had decorations outside of their doors, but considerably less than Violet's floor. Clara's room was the exact same layout as Violet's – very small, with a medium-sized window and a small desk. Unlike Violet's room, Clara had a few photos scattered around the room, none on the walls, but some on her bedside table, some at the desk, and some leaning against the TV. Clara sat in one of two large loveseat chairs in the corner of her room and invited me to sit in the other. During the interview – when she first mentioned her wife – she abruptly stood up and retrieved a photo of them together from

her bedside table. She showed me this photo with great joy and told me the story of how they met. Clara told me she felt lucky to have her wife because "a lot of people don't have anyone visit them here." As I left Clara's room after the interview, she stopped me to give me a candy cane.

My final interview was with Alice the following day. Alice had the exact same room as Violet and Clara, but hers was decorated with a variety of knitted, crocheted, and otherwise handmade items. I noticed she had a game of solitaire set up at her desk. Alice also had a large loveseat chair in her room, positioned so she could easily look out of her window. I pulled up the desk chair so we wouldn't be on opposite sides of the room. Alice told me that I "didn't look like a lesbian" but quickly followed up by saying, "I guess, not a butch lesbian at least." I joked with her that I left my button-up at home. During our interview, Alice and I talked a lot about her crafts and how she misses having a pet. She said that she "finds it quite lonely sometimes" but that family members will visit her occasionally. After her interview, she told me I could come back "anytime."

Each participant welcomed me into their home and shared a wealth of knowledge with me – both in relation to my research, and about their lives more generally. The following section provides an overview of emergent themes from interviews with these six participants, organized using a life course perspective. First, I will highlight participants' generational contexts – specifically in terms of the changing climate of 2SLGBTQIA+ issues – and life events that have informed their life (and housing) trajectories. Then, I will address the participants' catalysts for moving and the resultant planning for their later-life housing trajectory. Following this, I explore participants' experiences living in a congregate housing facility, specifically in terms of opportunities for building relationships with other residents, and how participants manage their

sexuality with staff and residents. Lastly, I describe participants' considerations for future housing.

Generational Context

I did not include any questions related to participants' experiences of "coming out" in my interview guide since, at the time of making the guide, I didn't consider its connection to experiences of later-life housing; however, all participants spoke about coming out as a process and as an important life event. Vera, Ruth, Violet, and Clara expressed that they knew about their sexual identity at a young age. For instance, Ruth (age 63) stated "I've known since I was probably about four. I knew something was different." Despite knowing at a young age, Ruth did not pursue lesbian relationships and, instead, recalled how "high school hit, and I went the exact opposite to hide it." Similarly, Clara (age 80) shared "I didn't know what it was called, but I knew I was attracted to women ever since I can remember." As a bisexual, Violet (age 75) described a degree of uncertainty about her identity in early life, stating "I always knew that I was attracted to girls, but I didn't feel like I was a lesbian. I had a lot of gay and lesbian friends growing up, and I think that let me… I don't know, explore?"

Unlike these participants, Mary and Alice became aware of their identities later in life. Alice (age 81) indicated that in retrospect, "I think I've always known; I never had a real interest in boys, really," but that she was "preoccupied with life" and, in turn, kept busy with work, travelling and even "dabbled with boys, but it was never serious." She stated that she "didn't spend much time thinking about it (her sexual identity)" and, like Clara, expressed that "maybe I just didn't have the right words to describe it." As Alice aged, she found herself thinking about it more seriously, noting how "I actually called up a friend of mine who was a lesbian to ask her about it," and following this discussion, she described "feeling a lot more comfortable with the

idea." Mary (age 62) realized her identity after her first marriage ended, and she found herself forging an unexpected relationship. In her words,

> So, my was-band, I call him, he *was* my husband… We broke up, and I just met a girl at work, and we were just chummy… And so, I was told she was gay, as a kind of 'just so you know,' and I was like, 'thanks, I guess.' I didn't grade her on that. I was just like, she's nice, and she's funny; we have lots of things in common. And so, we ended up dating. And then after that, I never went back to dating men. (Mary)

Participants spoke about a variety of coming out experiences, and how this life event forged new opportunities. For many participants, like Violet, coming out allowed them to transition into a "new life" (Violet). Clara stated how "it was like opening up into a community where I almost immediately felt comfort. I mean, there still were divides in the community, but they accepted me for being a lesbian." Ruth recalls that "back in our day, the world was so small for us. But you survived on finding these little enclaves where you could go." Ruth described taking road trips with Vera to the United States to spend time in well-established gay communities and commercial venues such as LGBT-only bars and resorts. She noted that "some of them are gay places with men and women. Some are just women, and some are just men." While most participants described feeling a sense of comfort – often because of a forged sense of belonging – by coming out, others reported finding comfort in remaining in the closet. Violet felt that by staying in the closet for some time, "I didn't have to decide my identity. I could keep exploring and trying to understand before puttin' it out to the world… I didn't want to take it back if I was wrong." However, upon feeling confident in her identity as a bisexual, Violet stated that she "never looked back." In contrast, Alice described, "I was…. and well, I guess I still am comfortable in the closet…It kind of relieves me in a way. I feel like I don't have to worry about anyone having an opinion on it, I guess."

Mary spoke to the unique cultural influences that shaped her identity as someone who is Two-Spirit and a lesbian. She described her experience in contrast to the older generation and in relation to her Indigeneity, stating that "for us (younger generation), it's different, and in Two-Spirited life, it's different." She shared how "as a younger person, I lived a straight life. …it wasn't a repressed like 'I have to be straight.' I never knew I was gay." As someone who came out later in life, Mary recounted how "it was weird for me at the beginning, because I was like, wow, am I gay?" She expressed that labelling her identity was challenging, until she "had a conversation with the elders, and they said, 'well, you don't have to be bisexual to be Two-Spirited,' because I was not up on the term." She concluded that she found comfort in exploring in her identity because,

> At the end of it for me, when it was explained to me in an Indigenous way. That, well, you can be Two-Spirited, and that doesn't mean you need to be bisexual. It just means that you are this person, that sees things the way you see them, and that's how you think. Now whether that's a cultural difference, or a learned difference, or a because you were raised in a family that didn't care if you were gay or straight. It's because of those things that you are Two-Spirited, Mary. Because you're that person. (Mary)

Following this conversation, Mary found that her identity became a point of cultural celebration, stating that "identifying myself now as Two-Spirited, because of my Indigeneity, it was celebrated."

Coming out was not always celebrated in participants' lives, with all participants reporting encountering interpersonal and institutional discrimination over the life course. Violet recalled, "I remember being told I had to decide, was I gay or not." As young, closeted lesbians, Vera and Ruth "were roommates for a looong time" (Vera – age 64). Vera proclaimed that she and Ruth "were together for 13 years while we were both in the closet" and characterized this time as "go[ing] under the radar." She added that "you had to fit in because you could lose your job. You wouldn't get an apartment. You wouldn't get a promotion." Vera witnessed this first-

hand, stating, “I know that Ruth was definitely held back from some promotions where she worked because she was a lesbian.” Vera stated that she came out because “the government did it. They sent out a census, and they said are you married? Are you single? Are you divorced? I made my own little box, and I put in same-sex couple… It pissed me right off.” When Ruth and Vera “went public, we only once really received a very, very nasty thing in the mail, so I consider that lucky” (Ruth). She explains that after receiving this letter, she “watched the news and the same form [of] letter was sent to a Jewish couple in a community.” She stated that this letter “look[ed] like the exact same thing that happened to us. So, somebody was using it as a way of saying ‘you're vermin.’” Likewise, Clara described an instance when,

> Me and my friends were leaving [LGBT bar], and I remember walking out of the door and seeing a group [of people] a little ways up the street. I didn’t think much of it at the time, probably because I had a few drinks… I went to light up a cigarette, and one of my friends said ‘run’ and grabbed my arm. It was a bunch of gay-bashers. (Clara)

Furthermore, Vera recalled how she came out during the AIDS crisis, and during this time, she “heard that people were passing away, and their partner would still be in the house that they owned with the partner that died, and their family would come in and kick them out and sell the house.” Years later, the climate of LGBT issues remained much the same, which meant that when Ruth and Vera “went to [a different province] to get married because you couldn't be married here (Ruth).”

Participants described considerable differences between generational cohorts of coming out and navigating homophobia. These distinctions were often made by younger participants (Vera – age 64, Ruth – age 63, and Mary – age 62) to contrast the political climate of LGBTQ+ issues in their generation, especially during their youth and early adulthood when they were, to that of the older generation. Vera posited that a main generational difference is that with “the older generation, they're so closeted.” Similarly, Ruth stated “it's a different generation, right? A

lot of those people went back. They went back into the closet." During my interview with Ruth, I spoke about the difficulties I had in recruiting members of this older generation for this project. In response, Ruth asserted, "they're scared, I am sure," alluding to this older generation's tendency to remain closeted. Both Ruth and Mary suggested that those who are closeted will never come out, regardless of any life event (e.g. they move from their community, their parents die, etc.) Mary describes how "it's generational, they don't want to. They don't want to come out. They're not going to. It doesn't matter if there's not a person, blood-related or friend in their whole life, they're not going to come out." In response to this, I told Mary that I, perhaps selfishly, felt sad hearing that members of this generation may never come out. I asked her if she shared this feeling of sadness, to which she responded:

> No, I don't. That's how they are. That's how they are; they're wired that way, they lived that way, they've seen the riots, they've seen the things, they did the whole thing. And it's more acceptable now, for sure. And that's their life, that's their person, it's in their DNA. That's how they've lived their whole life. They're not going to change at 60, 70, and 80. And so there will be the ones that will finally say, now I can finally breathe and be who I am. But they live in a community that won't accept that. So, they're not going to. If they're in this far, they're in, and their doors are closed. (Mary)

Mary suggests that despite being in the closet, members of this older generation will "perk up, and they'll find their people, and they'll find their commonalities." However, she reinforced the implausibility of coming out for this generation. She stated, "at this stage of their life, do they want to do that (come out)? They probably won't."

Younger participants (Vera – age 64, Ruth – age 63, and Mary – age 62) described their experiences in contrast to this older generation. Ruth spoke about the pivotal role of this older generation in "paving the way" and accordingly stated, "I don't consider us real pioneers, but I do consider that we took some of that on." When Ruth and Vera were coming out as a couple during their adolescence, Ruth recalls how "there were people that didn't know that they knew

gay people." This invisibility of LGBT people was reiterated by Vera, as she stated, "the only gay person we knew was Ruth's hairdresser." Ruth drew a distinction between growing up as a young lesbian and her experience today, noting, "we've been assimilated… at one point we were our own little enclave… What straight people don't realize is that we're everywhere now, and I'm not so afraid of being out." Moreover, Ruth expressed that her and Vera "are not going back in [the closet.]"

All participants alluded to a potential shift in the rights of LGBT people. For Alice, this shift was a positive one. She expressed "I think things are definitely progressing." Violet affirmed this perception of positive progress, describing how "you would have never seen a Pride crosswalk before." Vera finds that "things are gradually changing." She is hesitant about comparing generational experiences, first stating that "it's so much easier," and then pauses to reflect, following her initial statement by saying "well, I don't know if it's easier to be out now or not." Mary recognizes the significant progress made in LGBT rights but is hesitant about whether this progress will remain on an upward trajectory. She expressed that "the world is a mess right now with regards to gay people, with the rolling back of rights and all that kind of stuff." Mary explains that this sentiment is shared with friends, stating how "I know some of the group that we hang out with, they say, 'don't make me get on the soap box. I did this already.'"

In sum, participants' respective generational cohorts – and the political climate of LGBTQ+ issues during that time – had considerable influence on their community and relational contexts. While the older generation was seen as "paving the way" for LGBTQ+ rights, younger participants suggested that closeted members of the older generation are likely to stay closeted for the rest of their lives. In contrast to this, younger participants often spoke about being closeted in their youth and early adulthood, and since they've come out, how they are adamant

about never returning to the closet. All participants spoke about the invisibility of LGBTQ+ people, and the subsequent lack of language to accurately describe being lesbian, bisexual, and Two-Spirit. This invisibility often meant that participants did not know many LGBTQ+ people and had to travel out of the country to find small "enclaves" of LGBTQ+ people. Likewise, for Alice and Mary, the lack of language available to describe their identities created a pressure to come out as the "correct" identity the first time to avoid being "wrong." For Mary, the disconnect from her identity as an Indigenous person and culturally appropriate language to describe her sexuality was a challenge in claiming her sexual identity. Moreover, participants described coming out as a distinct life event that considerably impacted their lives, often providing new opportunities to forge a sense of belonging and community with other LGBT and Queer people. However, being "out" also meant that participants were subject to targeted homophobia. Participants generally felt that there is an increased acceptance and visibility of the 2SLGBTQIA+ community today, often citing public displays of Pride-related symbols (e.g. rainbow sidewalks), yet, noted concerns about ongoing anti-LGBTQ+ legislation. These insights from participants' generational contexts highlight the heterogeneity of older LGBT and Queer adults' experiences and their desired visibility in later life.

Preparing to Move

Participants identified a variety of catalysts for moving from their homes into their current housing accommodation. One of these catalysts was a change in the participant's family. Mary stated, "I lived with my son. There's a whole apartment suite above the garage, and in the back, so that's where I lived. Then his relationship ended." Following this breakup, Mary's son decided he wanted to move, and Mary thought, "well, I need a place to move to." Similarly, Clara recalled how "it was kind of a long process that built up over time. My partner had been

helping take care of me for the past five or so years, and as time went on, she just couldn't do it anymore. She was getting older too."

Other participants cited an anticipated or lived decline in their ability to accomplish activities of daily living as a catalyst for their housing transition. For Vera and Ruth, moving to independent living was anticipatory. Vera described, "I retired in 2018, and then we stayed in our house for another year, and we thought, ahhh, maybe we should sell the house." She spoke to the maintenance required to upkeep their previous home, specifically "all the shovelling, the mowing, and we had to replace the roof." She anticipated that as she and Ruth continued to age, these tasks would become unmanageable in the face of declining physical ability. She noted how "if you can't get out of your house without falling down… that's a real big issue. You're going to fall down, break your hip, and then next thing you know, you're over down the hill (at the long-term care facility)." Vera and Ruth considered staying in their home and hiring maintenance workers to help with tasks like shovelling to help ease their task load, in turn, allowing them to stay in their home for longer. However, Vera asserted that this choice was not as simple as deciding to hire a snow removal company. She describes that "unless you have someone really good, that's reliable and can show up to do your driveway, then forget it."

Violet and Alice spoke about the lived experience of declining physical and cognitive abilities that catalyzed their housing transition. Alice describes how her transition to assisted living was because she was "too old to be on her own anymore." When I asked Alice about what she meant by this, she said:

> I think it was just a sort of… a combination I guess, for lack of better words… A combination of small things that kind of piled up. Like, I would put something in the oven and forget it was there, or I wouldn't have the energy to dress myself. (Alice)

As she experienced decreasing levels of energy, Alice expressed, “I spent a lot more time in bed.” For Violet, this transition had been anticipated for a prolonged period, as her fibromyalgia had been limiting her physical mobility “for the past 30-odd years,” and as time progressed, her symptoms became more intense. Fibromyalgia is a chronic disorder that causes pain throughout the body, with some of its main symptoms being widespread pain, chronic fatigue, and muscle and joint stiffness (National Institute of Arthritis and Musculoskeletal and Skin Diseases, 2024). Following hospitalization after a fall, Violet recalled, “I remember thinking, well, maybe this is a sign that it’s time (to move into the LTCF).” She added “I really don’t think I had much choice anyway. Falling when you're my age usually means they’re sending you to a home.”

Four of the six participants spoke about doing research to find new accommodation. For instance, Violet said that she had “heard about [the organization], but I didn't know much about it, so I looked it up online.” Alice “recruited” members of her family to help her find a new living arrangement, specifically her “daughter, my son-in-law, and my granddaughter, their daughter, who is 26… she is the best with the internet out of all of us.” Participants named a variety of criteria they considered when researching future housing options. Vera, for example, chose her accommodation partly because “it was affordable.” In addition to its affordability, Vera valued its location, sharing that “we wanted to stay in the neighbourhood because it's where all our friends and neighbours were that we hung out with, and partied with, and so on.” Mary also valued the location of her housing accommodation, but for different reasons. She stated, “when it came time, I was like, ‘maybe I'll move to the city.’ And because my marriage with my ex-wife had ended, I didn't want to go back to [place name] because that's where she is, and it's a small town.” She also considered the location for its convenience, emphasizing that it’s one of “joys of living in a city, you can find what you want, and it's five minutes away.”

When researching housing options, participants from the independent living facility (Vera, Ruth, Mary) stated that they consciously considered the opportunity for socializing in future housing options. Mary sought out this opportunity "because when you live at home, *and* you work from home in a house, you don't see people, so it's certainly better here," referring to a higher likelihood of seeing neighbours in hallways and common areas. Since living in independent living, Mary has been pleased with the opportunities to be engaged in social life. As she stated, "it's as busy as you want it to be here, which is kind of great." When researching their now-current residence, Ruth considered her partner, Vera. As Ruth describes:

> I'm not big time into the social scene in here. But Vera is into it. I'll be honest with you, it's one of the reasons why I wanted to move in here is because I saw that there would be community here. And if for some awful reason I'm not here. She's got community around here, that's a more positive environment and she can do things. (Ruth)

Each participant spoke about researching whether their potential housing options were LGBT+ inclusive or not. Mary recalls how she "saw that they were inclusive. So, if I wanted to be in, I could be. If I wanted to be out, I could be." Vera identified that this research criterion is a unique experience for LGBT people, stating that "because I was a lesbian, I had read up on [facility], and they're very open and accepting." She did note that this displayed inclusivity did not absolve the potential of homophobia, but instead, "it's just how other neighbours perceive us." Ruth hesitantly spoke to a positive shift in this LGBT inclusivity in later-life housing policy, sharing how "the only thing I am happy about is with the laws changing, that if something happened and we both wound up going somewhere, then we could go together. Whereas before, it wasn't necessarily that way."

Overall, participants anticipated a later-life housing transition due to an expected decline in their ability to complete activities of daily living; however, family (i.e., Mary's son moving and Clara's partner being unable to continue providing care for her) or health (i.e., Violet's

hospitalization) changes catalyzed this transition sooner than expected for some participants. When possible, participants researched housing facilities prior to making their housing transition. As part of this research, participants cited a few key variables as part of their search: the geographic location of the facility, opportunities for socialization, and whether the organization was inclusive of LGBT and Queer people. Despite the continuing care organization advertising LGBTQ+ inclusivity, participants noted that this did not absolve opportunities for homophobic encounters with other residents. Ultimately, participants' experiences emphasize the diversity of catalysts for transitioning into later-life housing, their considerations when researching continuing care organizations, and the importance of these organizations publicly displaying their commitment to inclusivity.

Building Relationships

Vera and Ruth moved into their new home during the onset of COVID-19, which created barriers to building relationships with other residents. Vera recalls how "we came out here, and the movers were wearing masks. We had to wear masks in here for a long time… We were totally isolated. Our common room was closed, so we couldn't even meet anyone there." Similarly, Clara described that she was a resident during COVID-19 lockdowns, which, as she described, "were absolutely devastating for everyone in here." She stated that "we were on lockdown in our rooms, so many people were getting sick, and so many people were dying." She suggested, "I don't think the social life has been the same since (COVID-19)."

Since COVID-19 precautions have loosened, Vera finds that these shared spaces have allowed for engagement with other residents. She explained,

> We have a common room for this building, for the tenants here, on the second floor. Then we have a community room, where we do yoga, trivia, painting, and we have an on-site gym. Which is awesome. We're down there. And that's all included in our rent, which is fantastic. (Vera)

These spaces allow for structured engagement with other residents through the facility's social programming. These common spaces have also allowed residents to engage in informal social interactions. As Vera stated, “last year, we started a Blue Jays fans watching party. So, we go down to the common room and plug it in (technology), and we watch the Jays games… It’s a lot of fun.” Living in a congregate living setting has also allowed residents to help each other in the case of an emergency. Mary described an instance where there was a fire, stating “I was literally running up and down the stairs. Pounding on people's doors because they had no concept that they had to get the hell out of here. And I was lugging shit down to people's vehicles.”

Participants in the long-term care facility (Violet, Clara, and Alice) described how various barriers to these third spaces hindered their ability to socialize. Each of these participants expressed frustration with the facility’s elevators, which they required to get to the main area from their room. For example, Clara stated “we have three or four elevators, and everyone is always pressin’ all the buttons on every floor. It takes forever for one to finally come.” Similarly, Alice stated,

> You get a sense of relief when one of the elevator doors open, because chances are you’ve been waiting there for a while. But so has everyone else. So, you usually have to wait for another, because the first one is full of everyone who has been waiting… If I have an appointment or anything where I need to leave the building, I always plan to leave an extra twenty minutes ahead because of those things (the elevators) … and I need to catch my breath. (Alice)

Violet stated that “a lot of the chairs in [main area] are wood and have no cushion. They hurt to sit on. Sometimes, I bring down a cushion to sit on when I go there, but that doesn’t help my back.” She adds, “it’s not like I am going to tell someone to come talk in my room… what are we gonna do, both sit on my single bed?” Similarly, I wrote about the inaccessible design of the LTCF where the GSA took place in my observation notes:

> *"Today, as I sat down with Florence [the ally who attends the GSA] in the meeting room, I found myself drenched in sweat, just like I had the past four weeks. This was, in part, due to the uncomfortably warm temperature but also because the surprisingly wheelchair 'non-friendly' design of her floor and the elevator meant that we got caught on several bumps and corners on the journey to the meeting room. I felt guilty since I was pushing the wheelchair, and I felt that I was essentially pushing her into or over these obstacles. She assured me that it wasn't my fault, and that 'my floor isn't supposed to have people in wheelchairs' because it was assisted living, but it was manageable since she 'only needs the wheelchair to go far distances.' I don't understand why the whole building wouldn't account for wheelchairs..."* (Observation notes, February 23rd, 2024)

Clara described feeling intimidated about joining fellow residents in the facility's common areas. She recalled, "it's always the same people down there, and they are sort of their own group." I also noticed this pattern of people being in the same places each time I visited. In my observation notes, I wrote:

> *... As I walk down the hall to the GSA meeting room, I seem to encounter residents in the same place they were the weeks prior. For example, as I enter the lobby doors two women are sat next to each other, one of whom is always knitting while the other observes people coming in and out of the building. I say hello to them, and they give me a warm smile. As I pass through the lobby and pay for parking, a gentleman speeds by me with his walker and shouts, "hello Hannah," and in the same breath, says his trademark saying "too-daa-loo" as he heads down the hallway. As I walk down the hallway and through the sunroom, I see the same gentleman who is always dressed with a sort of cowboy outfit seated on a loveseat in the sunroom. He, like the last two weeks, tells me "I've decided I like it here." This is the third I have encountered these people (amongst multiple others) in the same place, at the same time. For a second I wondered if they were pranking me because it felt kind of like clockwork, but I've come to learn that many folks keep a routine each day, and I have become a small part of that routine…"* (Observation notes, February 9th, 2024)

In an attempt to encourage Clara to join in with the group she was describing, I asked her, "what's the worst that can happen?" She replied, "I've played it out in my head before. I think they'd all just go silent. And if it went bad, then I would be stuck seeing them around. There's no avoiding them."

Participants valued the structured social programming offered in their housing, as it provided opportunities for a sense of community. Vera states that "as far as the community,

there's so much to do here. Like, [the organization] have really set up programs to engage people, as long as they want to." In describing activities at her residence, Alice explains that they have "a gardening group, which I am really looking forward to with the warmer weather." Likewise, Clara stated, "I feel like there's always something to keep you busy; they'll take a [organization] bus to the farmers market, to Walmart…lots of places." Violet showed a particular interest in support groups being offered as a part of this social programming. She described that "there's so many groups here; they have a mental health support group, and I think they even have a group for the younger people here." Alice also expressed interest in the support groups, stating "it's great they have groups to keep us involved." However, for her, attending these groups was a rare occasion. As she described, "sometimes they happen during my afternoon nap… plus, it's not like anyone is going to notice if I go or not. There's no attendance list, so I don't feel… I don't know… it's easier to stay in bed."

In terms of building relationships, participants valued having shared spaces, such as common rooms, for opportunities to engage in formal and informal socialization. Informal opportunities to socialize with other residents were often based on shared interests (e.g., watching sports or playing cards). However, there were physical (e.g., uncomfortable furniture) and social (e.g., fear of being excluded) barriers to engaging in these shared interest activities, which were exacerbated by the onset of COVID-19. Participants also valued structured social programming facilitated by the continuing care organization, such as shared interest groups (e.g., gardening clubs) and mental health support groups. Despite their interest in social programming, participants found it easy to disengage or isolate themselves from these programs, due to their voluntary nature. These insights from participants highlight the importance of having both

structured and unstructured social activities, and the integral role third spaces have in facilitating this socialization.

Managing LGBT Identity

Participants spoke about the common experience of having fellow residents and staff assume they were heterosexual. As Violet stated, “sometimes it happens passively.” Likewise, Clara stated “I think most of the time, people don’t realize it; it’s sort of indirect in that way.” Ruth gives an example of this, stating, “I ran into somebody in the gym, and she was talking to me and asking me what my friend's name was. Because we have a two-bedroom, I guess we could be two sisters.” Mary spoke to this assumption being a trend amongst residents, stating “if you don't speak the words… people assume [you're heterosexual.]” She described that “I do fly under the radar… They've (residents) met my was-band coming for visits, coming for supper. And the fact that they've seen my kids. So, in their age group mind, they just assume I'm straight.” Alice spoke to similar instances where she was assumed to be heterosexual following a visit from a male family member. She expressed that “it doesn't, like, hurt my feelings per se, but it is something that I remember.”

Mary recalled a time when “one guy made a comment in here, and it was off… It was just a gay slur… And I turned around, and I called him out on it. But I didn't call him out like ‘did you just say that?’ I just said, ‘pardon me?’ and he straightened it out.” She noted that “it's just learned behaviour. There was no malicious intent,” and how, for him, “it was just regular,” it was “something in his friend group that he'd be comfortable saying.” Likewise, Clara described an instance where she overheard two residents “making fun of the [city] pride flyers,” describing how “they just thought it was stupid, like, that it was stupid for that to be in here because there's no gay or lesbian people.” Violet described an instance where nursing staff assumed that she was

heterosexual. She stated, “it was almost like they thought I couldn't be bisexual. I don't know if it's because I'm old, or I’m disabled, or what.” She continued to explain how:

> One time, I ended up correcting a staff because I just got kind of sick of it… I told them I was bisexual, and they said ‘oh, you're gay?’ and I just got even more upset about it. I know it's not that big of a deal, but I just said I was bisexual why are you calling me gay? (Violet)

Participants living at the independent living facility (Ruth, Vera, and Mary) spoke about staff helping them feel welcome in their housing. As Vera stated “everyone that's worked here, we have had no issues. In fact, they've bent over backwards to try and help us fit in.” Mary recalled an instance where “one time on the [organizations’] Facebook page, somebody made a comment; it was a homophobic comment.” Out of curiosity, I asked Mary if the comment was on a Pride-related post. She confirmed, “it was on a Pride-related post,” and added that “Vera contacted [staff], and [staff] was like “what?” and boom, it was gone in a nanosecond.” Mary continued, stating that staff are “very non-judgy that way. So that was one of the pluses about here. It ups your comfort level.” This support from staff was captured in my observation notes:

> “*When I walked to the GSA meeting room, I, like always, placed my refreshments on the large wooden table and arranged them so they would be accessible from a seated position. Then, I took off my jacket and turned to place it on the chair I was going to be sitting in. As I turned and my back faced the door of the meeting room, I heard a faint “hello” coming from behind me. Hopeful that it was a new resident coming to join the group, I enthusiastically said hello and quickly turned around to greet them. To my surprise, the faint hello did not come from a resident, but rather, a security guard dressed in a black and grey uniform that had “SECURITY” embroidered in a large black font. I began to sweat, in part due to the uncomfortably warm temperature the LTC home is kept at and because this security guard was now facing me – did I forget to pay for parking? Did I book the wrong room? In a stronger voice, she asked me: “are you the person running the … uh… group?” This pause was a familiar one – I had encountered it with various staff when they would ask me about the group, which I can assume is out of concern for saying the “wrong” thing and fear of offending me or the group. I immediately asked if she meant the gay-straight alliance, and she excitedly nodded. She told me that she thought the group was a great idea, as she knows some LGBT people at the care home and thought this group could be a welcoming space for them. I told her I was glad that she thought the space could be helpful, and that she knew of LGBT people here, but that only one self-identified ally came each week. A look of surprise and then*

> *confusion washed over her face. She told me she was sad that no LGBT people had attended but understood that being LGBT in their generation often meant "hiding." She assured me that she would spread the word about the group and left as quietly as she came in."* (Observation notes, March 8th, 2024)

Vera notes that the facility "posts things up during Pride," specifically for residents who "want to walk with [the organization]" in the Pride parade. Based on discussions with participants, this was the only LGBT-specific activity offered by the organization. Mary stated that she didn't mind not having LGBT-specific activities in her building, as her independence has allowed her to be "active in the gay community in whatever area that I've lived in." In contrast, Clara expressed missing the sense of community with LGBT people that she had prior to moving into the long-term care facility. She stated, "my wife and I had a group of lesbian and gay friends, mostly lesbians really… I miss that. I don't have that here."

Participants described managing their sexual identity when engaging with staff and residents. This identity management often happened because participants were assumed to be heterosexual. This assumption was apparent in conversations participants had with staff and residents (e.g., Ruth being asked what her friend's name is) or when residents overheard overtly homophobic comments being made by other residents. While participants recalled instances of staff assuming they were heterosexual, they also described experiences where staff acted in allyship with residents – making an active effort to include and stand up for LGBT and Queer residents. Further, the continuing care organization offered opportunities to participate (i.e., walking in the Pride parade) in the city's Pride festival; however, participants noted that this was the only opportunity to engage in Pride-related programming. Despite this, participants living in independent living were able to remain involved in LGBTQ+ community groups, given their increased ability to travel independently throughout the city, and their access to reliable transportation. Contrastingly, participants in the LTCF felt disconnected from the LGBTQ+

community since their opportunities to socialize outside of the facility were limited. These findings offer valuable insight into the negative impact of heteronormativity, namely through staff and residents assuming participants were heterosexual. These insights also highlight the integral role staff have in creating an inclusive environment for LGBT and Queer residents, and opportunities to engage LGBTQ+ residents with the wider LGBTQ+ community outside of Pride-specific programming.

Considerations for Future Housing

I asked residents of the independent living facility (Vera, Ruth, and Mary) whether they would consider living in long-term care. For Vera, this consideration would be a matter of "if we get to that point." Mary stated that she would consider living in "assisted living," adding, "I never want to be a burden to my kids." Contrastingly, when I prompted Ruth about whether she would consider living in long-term care, she said: "Uh, shoot me. Cause I'm not going there. Sorry. My desire is not to go there." When I asked her about why she felt this way, she stated, "I see some of those poor people, and I'm just like… *sighs* I can see why some people would feel they would go back into the closet in that environment."

These responses sparked me to probe residents of the long-term care facility (Violet, Clara, and Alice) about whether or not they had planned to live in LTC. As Alice explained, "it wasn't necessarily something I planned to do, but at the same time, I don't know what else I would have done. I don't have kids. I'm not married. So, I mean, who else would be taking care of me?" She added, "when I talk to other people in the [LTC section of the facility], I hear a lot of them talking about their family, so even having that doesn't mean…I don't know…people are busy, right?" Similar to Alice, Clara expressed, "it wasn't really something I thought about," noting how "it's the normal thing to happen. I put my mom in a home." With her wife's decline

in physical health, Clara found that “it just seemed like the right time. I didn’t want her to hurt herself helpin’ me.” For Violet, the transition into the LTC facility was expected; however, “I didn’t expect it to happen for a few more years… I’m one of the younger birds here except for the real young people here.” Violet noted “after I fell and I was in the hospital, I could tell the doctor wanted me to think seriously about it (moving into LTC). It didn’t feel like much of a choice.”

When discussing long-term care, participants spoke of a desire to create structural safety with an LGBT-specific housing option. As Mary recalled, having a “gay-specific long-term care home,” noting how “it's been discussed in [city] as part of OWLS, the Older Wiser Lesbians group,” a local community group for older lesbians. As she recalled this discussion, she stated that members of the group “joke about it” and how “they’ll call it the ‘Let's Be Inn.’” Similarly, Clara stated that “if there was a lesbian or even lesbian and gay long-term care home, I would have definitely wanted to be there.” Violet shared this enthusiasm about an LGBT-specific long-term care home. She stated, “if there was a place for us, that would be my number one choice.” Alice was hesitant about whether she would enter into a LGBT-specific long-term care home, describing how “I think for me it would feel like a bit of a jump,” referring to how she came out later in life.

Participants also described how safety and affordability would be variables for deciding whether they would move into an LGBT-specific home. Mary highlighted the importance of both affordability and safety, stating that “if the choices were available… available, affordable, and safe, then I would choose it. If it was $1,000 a month to live in the straight one and $1,200 to live in the gay one, I'd live in the gay one.” Mary states that if the place was unaffordable, like in the case that “it was $1,000 to live in the straight one and $2,000 to live in the gay one, then I'd

be in the straight one." Violet expressed concern about the likelihood of these facilities being affordable. She stated, "it'd be a sort of specialized home, so I doubt it would be something everyone could afford… Plus, there would probably only be one, which would make it more expensive too." Despite a desire for an LGBT-specific long-term care home, Mary described her fears about it being publicly known as an LGBT-specific place. She stated, "people go into churches and shoot because they want to shoot Protestants or Muslims or whatever. So, if it was well-known as a gay community, would that be a safe place? I don't know. I don't. That's my fear."

Ultimately, participants expressed mixed emotions about later-life housing options. While some participants felt that transitioning into a LTCF was a "normal" thing to do, often citing personal experiences with family members moving into LTC, others felt strongly about avoiding long-term care. Conversely, participants described a strong desire to have an LGBT-specific LTCF. When imagining this "specialized" facility, participants cited concerns about accessibility, affordability, and safety. These insights highlight the perceived normality of moving into LTC in old age, and the variety of opinions older adults have about this transition. Likewise, these findings emphasize an overall desire for LGBT-specific care facilities, while also shedding light on challenges in making these facilities safe and accessible to older LGBT and Queer adults.

In sum, these findings affirm the importance of understanding older LGBT and Queer adults' experiences of later-life housing through a life course perspective. As discussed earlier in this chapter, participants' generational cohort – and the political climate of LGBTQ+ issues they grew up in– has a considerable influence on their community and relational contexts. In turn, participants' experiences of coming out, finding a sense of belonging in the LGBTQ+

community, and navigating homophobia over the life course have informed their values and decisions about later-life housing. For example, when participants were preparing to move, they valued finding a continuing care organization that publicly displayed their commitment to inclusivity. Despite all participants recalling negative encounters with staff or residents, either because of an assumption of heterosexuality or an explicitly homophobic comment being made, most participants recalled instances where staff actively created a safe and inclusive space for them. Lastly, participants expressed a strong desire for an LGBTQ-specific long-term care facility on the basis that it was accessible, affordable, and safe.

CHAPTER FIVE: DISCUSSION

Using a Life Course Perspective to Understand Later-Life Housing

The present study seeks to understand the experiences of LGBT people living in later-life housing facilities, how their experiences are influenced by their sexual identities, and how they can be better supported in their place of residence. After conducting and transcribing six interviews with older LGBT adults who live in an independent living or long-term care facility and analyzing the resulting interview material, the following five themes emerged: (1) Generational context, (2) Preparing to move, (3) Building relationships, (4) LGBT-related experiences, and lastly (5) Considerations for future housing. This chapter will discuss these themes in the context of my research questions, which seek to understand the experiences leading up to participants housing transition, general and LGBT-specific experiences of living in congregate housing, and how residential facilities can better support LGBT and Queer older adults. To do this, I will begin by discussing relevant life events in the life course that have influenced participants' housing trajectories. Then, I will address the ways participants navigate later-life housing transitions into congregate living settings, focusing on general – meaning, not LGBT-specific – experiences that any older adult may have. I will then discuss experiences navigating later-life housing that were uniquely influenced by participants' sexual identities. Following this, I will consider how later-life housing facilities can better support LGBT and Queer adults. To conclude, I will briefly discuss the unexpected prevalence of lesbian stereotypes in resident interviews in relation to queer theories of aging, and then I will note the study's limitations and opportunities for future research.

LGBT & Queer Life Course

Participants often drew contrasts between themselves and other generations of LGBT people to contextualize their experiences throughout the life course and in later-life housing. Younger participants (Vera – age 64, Ruth – age 63, and Mary – age 62) often compared their generation to the older generation to highlight the progression of LGBT rights and the visibility afforded by these rights. Older participants (Clara – age 80, Alice – age 81, and Violet – age 75) affirmed these comparisons, citing pervasive homophobia as a contributor to the invisibility of their generation. According to Fredriksen-Goldsen (2016), the younger participants would be considered a part of the Pride Generation, and older participants would be considered a part of the Silent Generation. Fredriksen-Goldsen (2016) affirms distinctions made by participants about generational differences since LGBT adults from the Silent Generation are more likely to conceal their identity as they came of age during the criminalization and pathologization of homosexuality. In turn, members of the Silent generation adopted the strategy of "keeping things private" in order to evade queerphobia (Brotman et al., 2015, p. 115; Fredriksen-Goldsen, 2016; Knauer, 2011; Stinchcombe et al., 2021). This was salient amongst my participants, as residents of the long-term care facility often kept their identities to themselves despite being out, to varying degrees, and, in one case, in a same-sex marriage (Clara).

These generational comparisons provide a unique insight into age stratification theory (Foner, 1978; Riley, 1971). As Foner (1978) describes, each successive age cohort "bears the stamp of the historical context through which it flows, and as the process of cohort flow interweaves with historical change, it acts on the age structure of people and the age structure of roles" (p. S343). With the examples of the Silent Generation and the Pride Generation, it is evident how the gay liberation movement influenced the social roles of LGBT and Queer people,

re-emphasizing the importance of using a life course perspective (Elder, 1975, 1988) to understand 2SLGBTQIA+ older adult's experiences. For the Silent Generation, this meant keeping their identity hidden, whereas the Pride Generation took to heart ACT UP's (the AIDS Coalition to Unleash Power) counternarrative slogan of *SILENCE = DEATH,* coined in New York in the 1980s, to suggest that hiding one's LGBT or Queer identity meant complicity in the oppression of sexual and gender minorities, and at the time of the slogan's emergence, the deaths of people dying from AIDS (Gamson, 1989). Members of the Pride Generation (Vera, Ruth and Mary) embraced this slogan, with each of them stating that they would never return to the closet. This visibility afforded by the gay liberation and AIDS movement cannot be considered without noting the lives lost to AIDS. Vera spoke briefly about this in her interview, noting how people were dying, and their surviving partner would still be living in their home, until the partner's family would kick them out to sell the home. Experiences like these were common for members of the Pride Generation, as they were the most affected by the AIDS epidemic, bearing witness to the highest numbers of deaths related to AIDS between 1987 and 1996 (Rosenfeld et al., 2012).

Participants described a variety of distinct life events which can be attributed to their sexual minority status. One example of this is when Ruth and Vera spoke about having to travel outside of Atlantic Canada to another province where same-sex marriage was legalized. This is an example of the historical marginalization in social institutions, which often mark queer-specific life events as part of the life course (Fredriksen-Goldsen et al., 2015, 2017) and translate to instances of minority stress (Meyer, 1995, 2003). This story struck me during the interviews since I often think about same-sex marriage in Canada only in terms of the Civil Marriage Act, which legalized same-sex marriage across Canada on July 20^{th,} 2005 (MacIntosh et al., 2004).

However, it is important to note that each province had its own legislation prior to the Civil Marriage Act. For example, same-sex marriage was first legalized in Ontario on June 10th, 2003, then the following month in British Colombia (The Canadian Encyclopedia, 2024). Of the Atlantic provinces, Nova Scotia was the first to legalize same-sex marriage in September 2004, followed by New Brunswick in 2005, and Prince Edward Island only legalized same-sex marriage following the Civil Marriage Act in 2005 (The Canadian Encyclopedia, 2024; MacIntosh et al., 2010).

In the Atlantic Canadian context, some participants in Humble's (2012) study with 28 Nova Scotian LGBT older adults expressed a desire to wait until same-sex marriage was legalized throughout Canada, despite it being legal in Nova Scotia in 2003, since they wanted to have their legal status recognized in each province they visited. However, Vera and Ruth's experience adds a unique nuance to this, as they were willing to travel outside of their Atlantic Canadian province to become legally married and then return to their home province where their legal status wasn't recognized. This experience highlights the additional emotional and financial burden of Atlantic Canadian same-sex couples seeking legal marriage status prior to the Civil Marriage Act, which has been undocumented in previous research. Further, the legalization of same-sex marriage emphasizes Ruth's point of LGBT rights and inclusion, becoming preoccupied with being "assimilated" rather than liberation. Lannutti (2011) describes this idea of assimilation as "mainstreaming" and specifically notes that "older adults view same-sex marriage as a potentially mainstreaming tool" (p. 75). In turn, this finding emphasizes a need to understand the broader socio-legal context, specifically the interplay between regional legislation, visibility politics, and individual lives, to understand the unique life events and broader life course of the current generation of older LGBT and Queer adults.

Mary spoke of coming into her identity as being Two-Spirit and a lesbian later in life, after having two children and the dissolution of her marriage. Her experiences affirm Raphael and Robinson's (1988) early research that suggested late-blooming lesbians are more likely to adopt a lesbian identity after being in a heterosexual marriage and having a child, as opposed to remaining single and not having kids. Further, Mary said that she is involved with local LGBT community groups, affirming Goldsen's (2018) statement that coming out later in life is also associated with later involvement in LGBT communities and activism, compared to older adults who "came out" at a younger age who are less likely to be involved in LGBT communities and activism in later life. For Mary, these community groups were an integral part of living at the independent living facility, as they provided her with the opportunity to engage with the wider LGBT community in the area. Moreover, Mary discussed not wanting to become a burden to her children; hence, she would consider living in assisted living. As the only participant with children, this is particularly salient. While social science research has well-established that LGBT and Queer adults are less likely to have children and are therefore more likely to require formal care services (Fredriksen-Goldsen, 2017; Stinchcombe et al., 2021; Torelli et al., 2023), however, there has been less attention on the experiences of older 2SLGBTQIA+ adults who do have children. In aging research, scholars have noted that "there is a general trend away from expecting to count on one's children for care and toward expecting to age in place, which reflects the underlying desire for independence and avoidance of 'becoming a burden'" (Robison & Moen, 2000, p. 523). Mary's experience highlights this fear of burdening her children and suggests that older 2LGBTQIA+ adults who have children prefer to access formal care services than become the responsibility of their children.

Navigating Later-life Housing

Participants spoke of a variety of catalysts that led to their housing transition. Five of six participants discussed biological influences, specifically, an anticipated (Vera, Ruth) or lived experience (Alice, Violet, Clara) of physical disability that inhibited their ability to accomplish activities of daily living (ADLs). The sixth participant (Mary) spoke of a change in her previous living environment, sparked by her son, who owned the home, deciding to move. These catalysts are congruent with the reviewed social science literature on housing, which suggests that changes in health needs and social situations are the two greatest influences catalysts for later-life housing transitions **(**Beer & Faulkner, 2016; Bigonnesse et al., 2014; Clark & Lisowsli, 2017; Coulter et al., 2011; Kan, 1999; Rockwood et al., 2014). By transitioning from their home into an independent living or long-term care facility, participants were able to adjust their residential location to meet changing needs and preferences. For participants who were anticipating physical disability (Vera, Ruth), this move was made to maintain independence. For participants who had already been experiencing physical disability and changes in cognition (Clara, Alice, and Violet), this transition was directly into a long-term care facility to receive nursing care. As proposed in Litwak and Longino's (1987) seminal article, these residential moves can be considered retirement moves and care moves, respectively. Further, participants who lived in LTC identified catalysts congruent with research by Penning et al. (2018), which suggests that individuals with greater cognitive and ADL impairment were most likely to move into long-term care.

Vera mentioned successive, stepped accommodations to age in place. To begin, Vera spoke about anticipated challenges in upkeeping home maintenance, specifically with the example of snow removal. In recognition of declining physical ability and the fear of fall risk, if

they continued to do their own snow removal, Vera decided to hire a snow removal company. This was the first attempt to accommodate her and her partner Ruth's living environment to allow themselves to age in place. However, due to unreliable snow removal services, they decided to downsize their home by transitioning into an independent living facility. By moving into an independent living facility, responsibilities regarding home maintenance (i.e. snow removal) became the responsibility of the continuing care organization rather than the individual participant. This transition is considered another accommodation to age in place since they transitioned into a new environment of their choice – outside of a long-term care facility (Cao & Hou, 2022).

Likewise, this experience coincides with results from Bigonnesse et al.'s (2014) study, with the exception that participants in this study were not seeking home maintenance services following the death of a spouse. This finding reiterates the need for accessible, affordable, and reliable home maintenance services for older adults, as having these supports in place may have allowed Vera and Ruth to avoid multiple moves, which, as Redden (2023) reminds us, is a common desire amongst aging adults. While Bigonnesse et al. (2014) described how the meaning of home is influenced by older adults' capacities to take care of their home, Vera's example of shedding home maintenance responsibilities suggests that the meaning of home is rooted in autonomy over personal involvement in their home, rather than the actual involvement in ADLs related to home maintenance. The independence afforded by self-accommodation allowed Vera (and Ruth) to maintain a sense of safety, which ultimately provides a feeling of being "at home" and a sense of belonging that is critical for wellness in later-life (Cater et al., 2022; Gillsjö et al., 2011; Prieto-Flores et al., 2011).

In discussing catalysts for their housing transition, participants also highlighted their attachment to place in regard to their previous home. Participants (Vera, Ruth, Alice, and Mary) spoke about wanting to stay close to their neighbourhood, as they had social and emotional ties to their community. This attachment to place and opportunity for social connection is what Leibing (2016) describes as a "defining element of what makes a home a home" (p. 16). Participants who moved directly into long-term care (Clara, Alice, and Violet) grieved this attachment to place, as their care move meant that they had less choice in their place of residence (Litwak & Longino, 1987). The care move was particularly abrupt for Violet following a fall that led her to the hospital. This experience aligns with Kan's (1999) finding that care moves are likely to be sudden and, by extension, unplanned, depriving them of the stepped process of moving outlined by Coulter et al. (2011). Since Alice was experiencing milder symptoms of physical disability and cognitive changes, she was able to move as a process including "some form of preference-formation, deliberation, and destination-choice processes" (Coulter et al., 2011, p. 2744). This may explain why Alice described living in the long-term care facility more positively than Violet and Clara, as she was able to exert autonomy over her choice of facility.

Likewise, participants described their desire for socialization as a catalyst for their housing transition, or as something they appreciate now as current residents. Participants described social interactions happening informally in shared spaces of their facility, such as a Blue Jays watching party (Vera) or seeing the same groups of people getting together on a regular basis (Clara). These informal interactions in the facility's common areas reiterate the importance of shared spaces as a dimension of housing design for aging adults (Cater et al., 2022; Leviten-Reid & Lake, 2016). This was further emphasized in Mary's interview when she described helping fellow residents who were older than her and had restricted mobility, during an

evacuation. Participants also described the benefits of these spaces in relation to social programming that happened within them. While some participants (Violet, Clara, and Alice) described barriers to engaging in this programming, they still valued them as an opportunity for socialization.

Participants in this study described how the COVID-19 pandemic influenced their experiences of later-life housing. For Ruth and Vera, the onset of the pandemic coincided with their transition into the long-term care facility, which meant that they were isolated from meeting fellow residents upon their arrival. Contrastingly, Clara described the fatal impact of COVID-19 on the long-term care facility, noting the challenges lockdowns imposed and the deaths that occurred from the virus. With the onset of the COVID-19 pandemic happening in early 2020, considerable social science literature has emerged over the past four years on the early impacts on population health. A notable amount of this literature has been focused on the disproportionate effects of COVID-19 on congregate living setting, including independent and long-term care facilities (CIHI, 2021; Koncul et al., 2023; Ren et al., 2024). For example, in February 2021, it was reported that 69% of all deaths related to COVID-19 were residents in LTC (CIHI, 2021). Many scholars have suggested that the built environment of congregate living spaces was to blame for the devastating effects of the pandemic (Ren et al., 2024).

Navigating Housing as a Sexual Minority

All participants spoke about instances of what can be understood as minority stress (Meyer, 1995, 2003) related to their sexual identity in their experiences of later-life housing. While transitioning into later-life housing is not unique to LGBT and Queer older adults, participants' precursory event of researching whether the continuing care organization is inclusive is a distinct instance of minority stress. This finding is particularly interesting since

residents of the long-term care facility weren't relatively open about their identity. However, as Mary spoke in her interview, knowing that the continuing care organization was inclusive gave her the option to be open if she wanted to. Participants described a variety of encounters with queerphobia from fellow residents, staff, and on the continuing care organization's social media. Queerphobia itself constitutes as minority stress since it is targeted toward LGBT and Queer people (Meyer, 2003). However, having to deal with queerphobia as an LGBTQ+ person in your place of residence is an additional source of stress. These instances of minority stress highlight the need to "direct relevant interventions at both the individual and structural levels" (Meyer, 2003, p. 24).

One opportunity for structural intervention is through LGBT-specific housing options, which most participants spoke about. This desire for LGBT-specific housing is not new for older LGBT adults, as evidenced by Almvig's (1982) qualitative study with older lesbians. All participants who expressed interest in this kind of facility stated they would be open to gay men and lesbians residing there – as well as transgender people. This finding contrasts with that of Westwood (2016), who found that "gender remains an important distinguisher in the participants' housing preferences," with women a part of Westwood's study often preferring women-only housing rather than mixed-gender facilities (p. 160). One reason for this contrast may be because there are currently no LGBT-specific facilities in Atlantic Canada, therefore, participants may feel inclined to have it non-gendered to allow the greatest access to a potential facility. In 2010, Spirit Place was proposed as a "seniors complex that will focus on welcoming gay, lesbian, bisexual and transgendered seniors" in Halifax, Nova Scotia, but was rejected by the city council in 2013 due to its purportedly large design and the required rezoning of the block (CBC News, 2011, para 1, 2013). Despite this being the only proposed LGBT later-life housing

facility in Atlantic Canada, none of the participants explicitly spoke about it (although, they may not have heard of it). In the event that LGBT-specific housing for older adults is reconsidered, future research could explore avenues for intergenerational housing for the 2SLGBTQIA+ community, as it could help facilitate intergenerational connection amongst 2SLGBTQIA+ people (Weststrate et al., 2023).

When participants discussed the potential for LGBT-specific facilities, they also cited affordability as a key consideration. The need for later-life housing to be affordable is a salient theme in social science literature. Given the combination of the unaffordability of housing in Canada with the financial inequities faced by some LGBT people, housing options are considerably limited (Redden et al., 2023; Stinchcombe et al., 2021). Redman (2012) asserts that this financial component is often overlooked in LGBT populations as the "myth of gay affluence," which is hinged on the experiences of white, wealthy, childless gay men, is passively assumed (p. 451). Dispelling this myth is critical for understanding the experiences of lesbians, given that they are subject to career pay disparities, many have children and are more likely to be responsible for childcare as well as eldercare because they are women (Novak et al., 2018). These experiences are compounded by their lesbian identity and the likelihood of discrimination in economic opportunities based on their sexuality (King, 2016). Vera spoke about one example of these financial inequities, noting that she felt Ruth was held back from promotions because she was a lesbian. This was an interesting contrast to Minnegerode and Adelman's (1978) study, which found that none of the lesbian participants reported discrimination against sexual preference and, instead, felt constraints because they were women. While these LGBT-specific facilities may act as a structural intervention toward counteracting minority stress, Mary noted a

concern about whether it could be considered a safe place since, for her, having it publicly known as an LGBT place may catalyze targeted violence.

Another opportunity to promote structural safety is through adopting an inclusion scheme. An inclusion scheme provides direction into the challenges with inclusion strategies, such as staff education (discussed in chapter one) and removes the onus from individual staff to complete these training activities (Pijpers & Honsbeek, 2023). Scholars (for example, Pijpers & Honsbeek, 2023; Willis et al., 2017) suggest that later-life housing facilities would benefit from an inclusion scheme since it would be an opportunity to provide a more holistic, comprehensive approach to improving the lives of LGBT and Queer residents. Participants described a variety of experiences that would be targeted with this inclusion scheme, including researching whether the organization is inclusive, having staff assume they are heterosexual, and queerphobic comments from fellow residents. Since residing in an LTC corresponds to living in an environment "in which heterosexuality is presupposed" (Torelli et al., 2023, p. 3130), this inclusion scheme would target these negative experiences and act as a long-term, open-ended, and comprehensive approach with the goal of sustaining attention to gender and sexual diversity (Pijpers & Honsbeek, 2023). One example of an inclusion scheme is the Pink Passkey. The Pink Passkey has become a certified program for recognizing LGBT-friendly practices, and this inclusion scheme is promoted by COC Netherlands, which is one of the oldest LGBT+ advocacy organizations in the world (Pijpers & Honsbeek, 2023).

Stereotypes

Every participant spoke – a *lot* – about LGBT stereotypes, both indirectly in the flow of conversation, or directly about the stereotype itself. This theme was surprising to me, in part due to the quantity of stereotypes referenced and because of the prevalence of the same stereotypes in

my generation. These stereotypes included assumptions about lesbians adopting traditionally masculine roles (e.g. building a house, being a "hardcore sports player and watcher," "taking care of things" in the household) and presenting as either masculine (e., wearing plaid, having short spiky hair) or hyper-feminine (e.g. long hair, wearing dresses, putting on makeup), colloquially known as "the lipstick lesbian." It was interesting that participants used the language of "masc" (short for masculine) as an identity label, rather than "butch" or "dyke", which I often associated with older generations of masculine Queer women. Likewise, participants used the term "lipstick lesbian" to describe hyper-feminine Queer women, rather than using "femme" as an umbrella term for non-masculine Queer women. It stood out to me that identity labels for masculine women were an umbrella term (i.e., masc), and participants often delineated more niche identity labels for feminine women (i.e., lipstick lesbian, chapstick lesbian) in addition to using "femme" as an umbrella term.

Personal interest aside, the continuous mentions of stereotypes were an unexpected finding. Most of these stereotypes were specific to lesbians, which can be attributed to all participants being attracted to women and identifying as a woman themselves. However, I think it's relevant to note that more niche identity labels for feminine-presenting women included the word "lesbian" in the identity label, whereas "masc" was used independently. This difference may point to heteronormative assumptions of gender, by implying that masculine-presenting women are lesbians, and feminine-presenting women are heterosexual (Eves, 2004). Likewise, the variety of niche identity labels to describe femme lesbians may suggest that Queer women's incongruence with heteronormative assumptions of gender requires numerous and specific descriptions (i.e., labels) to explain the negotiation of gender and sexuality. With this, I argue that the idea of older Queer women being a "triply invisible minority" (Kehoe, 1986, p. 139)

becomes further nuanced in the case of femme lesbians. While a masculine woman is likely to be perceived as a lesbian "because her sexual style is considered 'blatant'" sexuality (Walker, 1993, p. 886), feminine lesbians experience a negotiated visibility, providing them greater visibility as older women, while their sexual identity is made increasingly invisible, due to their gender expression and older age.

Additionally, something that was particularly unexpected about the stereotypes participants referenced was how many were about lesbians ignoring and defying time as a variable in the life course. This abstract measure of time was never used in reference to age or the process of aging, the way it is for gay men in the case of accelerated aging (e.g., the idea that a gay man is old when he turns 30) (Berger, 1982; Schope, 2005). Instead, these exaggerated timelines alluded to the uniqueness of lesbian romantic relationships by virtue of not conforming to standard (i.e. heterosexual) partnership-related life events. For example, Vera spoke about celebrating her and Ruth's 40th anniversary, noting how "that's 250 years in lesbian life." Speaking to this same anniversary, Mary compared 40 years of lesbian partnership to "500 lesbian lives." These exaggerated timelines also happened in the inverse, wherein lesbians were stereotyped to move quickly in relationships. This meant that typical timelines for dating were expedited. Many participants who spoke to this stereotype referred to it in the context of moving in quickly with someone they were dating for only a few months. This stereotype is often referred to as "U-Hauling," and each participant spoke to it by this name.

These expedited timelines may be the reason that lesbian relationships are stereotyped as being lifetimes longer; however, it is also worthwhile considering these exaggerated timelines as evidence of Kimmel's (1978) notion of "crisis competence." As discussed in chapter one, crisis competence is a unique attribute formed as a result of navigating queerphobia throughout the life

course and is argued to provide older LGBT adults with skills to cope with the challenges of aging (Bower et al., 2021; Heaphy et al., 2004, 2007; MetLife & American Society on Aging, 2010). Some scholars (for example, Almvig, 1982; Kehoe, 1986; Novak et al., 2018) emphasize older lesbians as being particularly skilled in crisis competence since their relationship with mainstream (i.e. heterosexual) culture is generally one of coping. The overwhelming salience of these stereotypes has been documented in other social science research on lesbians. For example, Gordon (2006) stated that "the only guideline the participants see for how lesbians should date or relate sexually is in the form of the U-Haul joke", emphasizing its pervasiveness in lesbian culture (p. 187). Kley (2011) asserted that gender plays a role in influencing housing transitions, with women's decisions being more strongly influenced by the life course domain of partnership than men's. Lesbian stereotypes can, in part, be explained with this gendered lens, as partnership-related events like moving in together and marriage influence women's housing transitions more than men's. However, this does not explain the exaggerated timelines that are engrained in stereotypes about lesbians. With a lack of explanation for this stereotype, future research could expand beyond documenting these stereotypes to explore how stereotypes about LGBTQ+ people become embedded in later-life health and housing services, and how specifically these stereotypes can be challenged to inform inclusive policies.

LGBT Programming

A second unexpected finding which emerged in interviews with residents was the lack of a desire for additional LGBT programming from the continuing care organization. I preface this finding by saying this apathy could be explained by the generationally influenced openness about their sexual identities and, for some, their ability to travel independently outside of their housing facility and into the community. For example, the two oldest participants spoke about their

"comfort" in the closet, alluding to a sense of relief from having a limited amount of people know about their sexual identity, and their resultant disinclination for having all residents know about their sexual minority status. In turn, these participants were disinterested in LGBT programming, as they preferred to stay "in the closet" in their LTCF. These sentiments, as previously discussed, are representative of the Silent Generation (Fredriksen-Goldsen, 2016).

Each of the three younger participants spoke about travelling out into the community, either for LGBT-specific community groups or to visit friends who were LGBT. Having the ability to freely engage with the LGBT community likely influenced not wanting structured programming. Further, they all stated how they were the only LGBT people in their building, aside from one gay man who they did not regularly engage with because of him being in poor health. Mary spoke about how she couldn't be sure that they were the only LGBT people, as she claims not to know much about her neighbours, let alone other people in the building. Perhaps paradoxically, she also expressed how she was assumed to be heterosexual, as her ex-husband and children came to visit. While none of the literature I reviewed spoke to LGBT residents in congregate housing facilities, assuming they were the only LGBT people, this theme was apparent in the literature amongst LTC nursing and administrative staff (Torelli et al., 2023).

Limitations

Despite this project's recruitment efforts being directed toward LGBT & Queer older adults broadly, all participants identified as female, with five identifying as lesbians, one of whom is also Two-Spirit, and one identifying as bisexual. Likewise, interviews were conducted by myself, a white, Queer, young person, which may have led to an initial distrust on the part of older LGBT adults, as the 2SLGBTQIA+ community is typically youth-centred and as participants noted, members of my generation seldom engage with older generations. While this

engagement was one of the goals of my thesis, I recognize that having this point of contact be used as a source of data collection could be considered extractive by older LGBT adults. This limitation is supported by the fact the three participants who lived in long-term care resided at the initial site selected for this research, which meant that these participants could have known about the gay-straight alliance or seen me regularly visiting the care home, providing them with a sense of comfort. In contrast, residents of the second long-term care home, that was included following a Research Ethics Board amendment, would have only viewed recruitment posters asking for their participation in an interview, rather than also inviting them to the gay-straight alliance like in the initial LTCF. As discussed, the small sample size does limit the ability to attribute differences in experiences (e.g. experiences of homophobia, another thing) to individuals' type of housing accommodations or sexual identity. In turn, data was interpreted based on themes in data, and when relevant, when comparing residents' experiences (for example, differences reported between those living in independent living and those living in long-term care), these contrasts are not assumed to be generalizable.

CHAPTER SIX: CONCLUSION

Social scientists have studied aging and later-life housing for decades, yet have only recently considered the experiences of LGBT and Queer aging adults in these contexts. These new considerations have been sparked by older LGBT people being out and visible. In this thesis – which sought to understand the experiences leading up to participants' housing transition, general and LGBT-specific experiences of living in congregate housing, and how residential facilities can better support LGBT and Queer older adults – I have argued that it is integral to understand the lived experiences leading up to and within later-life housing as inherently connected to older LGBT and Queer people's generational context. The residents interviewed within this study identified their cohort's proximity to the gay liberation movement as influencing their experiences of being LGBT and living in later-life housing. In turn, this thesis argues that older LGBT adults experience later-life housing differently than their heterosexual peers due to their sexual minority status.

Residents described their experience living in later-life housing as being manageable and, at times, positive, despite interacting with structural and interpersonal homophobia. These positive experiences of later-life housing were made possible by having a connection to the LGBT community, having fellow residents act as allies, and being supported by staff. When residents expressed general (non-LGBT specific) fears about later-life housing, they were hinged on expectations of physical and cognitive decline, social isolation, boredom, or simply that their "desire is not to go there (LTC)" (Ruth). Contrastingly, fears described as stemming from their sexual minority status were in anticipation of exclusion. While older participants expressed their relative comfort in the closet while residing in long-term care, younger participants who

currently live in an independent living facility clearly and powerfully stated that they would never return to the closet.

This thesis offers a variety of practical recommendations for supporting older LGBT adults in later-life housing. Although all participants are women – five of whom were lesbians, one of these lesbians being Two-Spirit, and one who was bisexual – their experiences and recommendations for housing speak to ways of supporting gender sexual minority older adults more broadly. Firstly, participants spoke about their desire for an LGBT-specific long-term care home. This desire has been reiterated throughout social science literature (Johnson et al., 2005; Pang & Maclennan, 2023; Redden et al., 2023; Torelli et al., 2023), even appearing in the earliest empirical works (Almvig's, 1982). Secondly, participants spoke to the desire for staff education about LGBT issues, for example, to teach staff about the harms of assuming residents are heterosexual. As suggested by Pijpers & Honsbeek (2023), offering a one-day training is still preferable to doing nothing; however, a more ideal intervention would be a long-term sustained effort like an inclusion scheme (Pijpers & Honsbeek, 2023; Sussman et al., 2018; Willis et al., 2017). What is most important to note is the heterogeneity of experiences, needs, and desires of later-life housing among participants. As the key finding for this thesis, I emphasize the need for inclusion strategies and interventions to account for this heterogeneity rather than adopting a one-size-fits-all approach. This could happen through adopting an inclusion scheme, such as the Pink Passkey, that targets both staff and residents in LTCF's and recognizes the importance of generational context in creating sustained attention to sexual and gender diversity (Pijpers & Honsbeek, 2023).

Having lived through some of the most "conservative and politically repressive climates," LGBT and Queer older adults have experienced "intense vulnerability, oppression,

and discrimination in all realms of their social lives" (Brotman et al., 2015**,** p. 113). As this cohort continues to age, later-life housing organizations and initiatives must consider the unique cultural context of LGBT and Queer older adults to provide them with an inclusive, safe place to call home. My thesis has provided an opportunity to understand the experiences of older lesbians and bisexual women in later-life housing, and to reflect on how they can be better supported in the place they call home. In doing so, my thesis helps fill a long-sustained gap between aging and sexuality research.

Future research could diversify the methods used in research with older LGBT and Queer adults. Methodologically, much of the research on older LGBTQ+ adults have been confined to traditional quantitative (e.g., surveys) and qualitative (e.g., interviews and focus groups) methods. In turn, future research could explore opportunities to engage other methods, such as arts-based methods or community-based participatory action research (CBPAR). The value of arts-based research comes with its relational, embodied, and affective nature (Oswald, 2019), which allows a unique avenue to explore complex social phenomena – such as LGBTQ+ aging. Further, engaging in CBPAR with older LGBT and Queer adults can help mitigate concerns about extractive research, while also creating interventions to address health disparities amongst older 2SLGBTQIA+ adults (de Vries & Croghan, 2013; Wright et al., 2017).

As mentioned in chapter five, future research could further investigate the experiences of older LGBTQ+ adults in later-life housing. One opportunity for this is to explore the ways stereotypes about LGBT and Queer people have become embedded in later-life health and housing services, and how specifically these stereotypes can be challenged to inform inclusive policies. Similarly, future research could also address the need and desire for LGBT-specific housing in later life. By recognizing the challenges in establishing intergenerational connections

amongst 2SLGBTQIA+ people (Weststrate et al., 2023), future research could explore avenues for intergenerational housing for the 2SLGBTQIA+ community, which would provide structural safety due to being LGBTQ-specific while also providing an opportunity to investigate deinstitutionalizing later-life housing models.

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Appendix A: De-Identified Interview Guide

1. How long have you been a Resident of [long-term care facility]?

2. As you know, in order to be interviewed for this project, you must be a member of the LGBT community. Could you tell me about how you identify within this community and what that identity means to you?

3. Before you entered [long-term care facility], did you ever think about how being LGBT may influence your experiences moving here? *Reworded if needed: Was your identity something you thought about when deciding to move – perhaps, whether or not you would disclose your identity?*

4. How do you think your LGBT identity has affected your transition into [long-term care facility]?
    a. Has this changed since you've been living at [long-term care facility]? for ____ *(answer from Q1, ex: 2 years)?*

5. Do you find yourself managing your LGBT identity while living at [long-term care facility]? *Meaning, do you ever intentionally withhold or change information about your identity, or think about how you will be perceived differently if you disclose being LGBT to someone?*

6. Have you experienced your LGBT identity differently since living at [long-term care facility]?
    a. *For example, do you feel like you are more (or less)"out"?*

7. How has your experience been meeting other residents?
    a. Has this experience been different when meeting LGBT Residents, as opposed to non-LGBT residents?

8. Can you tell me about how you experience community within [long-term care facility] as an LGBT person?
    a. Is this different than your experiences of community prior to living at [long-term care facility]? *For example, if you used to frequent LGBT-designated events/spaces, are you still able to do so?*

9. How do you think LGBT people could be better supported here?

10. *IF APPLICABLE):* Could you tell me about your experience with the weekly GSA group?
    a. What do you think worked well in this group?
    b. What do you think didn't work so well?

11. Is there anything that I did not ask you that you wish to tell me?