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Social participation and community engagement of older gay and bisexual male veterans: Time to ask and tell

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Methods: This action research explores perceptions and understandings of what it means to be LGBTQ later in life. The study includes data from seven semi-structured interviews with gay and bisexual male veterans ranging in ages from 51--87.

Results: Interviewees valued social opportunities as a means of human connection within a community. Five issues emerged from the data including: communal meals, transportation, housing, the coming-out process, and trauma and mental health.

Discussion: Trauma-informed care is essential when working with marginalized populations. Occupational therapy practitioners may support health and wellness for LGBTQ elder veterans by creating programming facilitating community engagement. Further research is needed to implement alternative courses of action.

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There are approximately 22 million United States (US) veterans nationwide. An undetermined number identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ). Information regarding this population is limited. Researchers acknowledged that the September 2011 legislation to repeal the “Don’t Ask, Don’t Tell” (DADT) policy has created the need to offer more community-based services to LGBTQ senior veterans across the nation (Sherman et al., 2014). All veterans, regardless of sexual orientation have inconsistent health indicators, including geographic accessibility of healthcare, extent of benefits, health literacy, health disparities, health insurance coverage, and education regarding available benefits (Blosnich, Bossarte, Silver, & Silenzio, 2013). The primary aim of this study was to explore the perspective of older LGBTQ veteran’s experiences with community engagement and social participation. The secondary aim of this study was to involve LGBTQ veterans in determining alternative community supports for health and wellness.

**Literature Review**

The national organization supporting LGBTQ older adults, Services and Advocacy for GLBT Elders (SAGE, 2014), recognizes 1.5 million people in the US identify as LGBTQ and are 65 years of age or older. This number is expected to double within
15 years. The Administration on Aging (2015), a federal organization that compares statistical census information, estimates this number to be significantly higher at 1.75 to 4 million. A major issue concerning this population is the difficulty of measuring how many older Americans identify within the LGBTQ community; especially when other demographic information such as race, ethnicity, socioeconomic status, age, and geographic location is considered (Campbell, 2013). This continues to be a barrier, affecting how healthcare services are offered to aging LGBTQ Americans.

In 1952, the American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) defined homosexuality as, “a sociopathic personality disturbance” (American Psychiatric Association, 1952). The DSM continued to list homosexuality a mental illness until 1973, at which time it was removed as a diagnostic category (American Psychiatric Association, 1968; American Psychiatric Association, 1973). According to Haber (2009), the DSM was supported by research that claimed homosexuality was a fear of the opposite sex, attributed to traumatic familial relationships. Unfortunately, this idea reinforced the stigma of being gay and strengthened the acceptance for unlawful discrimination and social persecution of LGBTQ individuals.

Today, a person who identifies as LGBTQ and is 65 years of age or older will have also experienced pivotal moments in gay history that coincided with the American Civil Rights Movement. The Stonewall Riots of 1969, which occurred on Greenwich
Village streets in New York City, remain a monumental event in LGBTQ history. This event sparked national controversy that resulted in multiple protests and gay pride activism around the country. The HIV/AIDS epidemic of the late 1970s and early 1980s also shed negative light upon the LGBTQ community. The public viewed homosexual men as spreading “gay cancer” because the immunodeficiency disease did not yet have a name (Wright, 2006). Campbell (2013) argued, “... discrimination, stigma and a lack of knowledge on the part of many health providers means these individuals frequently do not access the healthcare they need.” Even though access to resources has drastically changed within their lifetime, particularly through technology and communication, LGBTQ seniors largely rely on friends to help them navigate the complicated U.S. healthcare system safely (Howard, 2013).

LGBTQ older adults, regardless of service connection, are at higher risk for social isolation, discrimination, depression, workplace stigma, and community instability (Johnson, Rosenstein, Buhrke, & Haldeman, 2013; Couture, 2010; Grossman, D'Augelli, & Hershberger, 2000). Members of this population often endure multiple layers of stigmatization in regards to gender, race, ethnicity, and sexual orientation (Johnson & Buhrke, 2006). The current generation of LGBTQ elder veterans were required to lie in order to serve the country. The DADT legislation of 2011 prompts opportunities for change for veterans and care providers to improve health and wellness.

**Methods**

*Research design*
Participatory action research (PAR) is a means to systematically examine an issue from the perspective of persons living the experience. Community members often serve as integral partners in the process of defining an issue, determining alternative approaches to the issue, choosing a course of action, and evaluating outcomes. Cockburn and Trentham (2002) described in depth the current trend for occupational therapy practitioners to integrate participatory action research (PAR). The approach is most frequently used with clients perceived to be members of marginalized communities. Taylor, Bravemen, and Hammel (2004) further illuminated the use of PAR developing and evaluating social change within community-based services. There are generally six steps to PAR (Taylor, Bravemen, & Hammel, 2004): 1. identifying a specific issue, 2. identifying options and choosing a solution, 3. designing an approach and means to determine outcomes, 4. taking action, 5. collecting data, and 6. reflecting on the process and outcomes to influence future actions. The authors used phenomenological methods of storytelling and observation to gain insight into the participants’ perspectives and involve participants in the process of exploration.

Participant Selection

The first author engaged in purposeful sampling of information-rich cases. The first author approached a convenience sample of LGBTQ elder veterans participating as members of community-based programs within the Pacific Northwest. The first author also used snowball sampling to identify addition informants within the local network. Participants met the following criteria: a) a U.S. veteran, b) over the age of 50, and c) a self-identified member of the LGBTQ community.
Data Collection

The first author contacted potential participants in-person, by telephone or e-mail to introduce the project and describe expectations. Each participant chose a quiet and safe environment in which to participate in an interview. The first author reviewed a letter of informed consent with each participant, after which each participant signed, dated and selected an alias. The first author conducted a semi-structured interview with each participant using a categorized interview guide including the following topics: demographic information, veteran service experiences, dishonorable discharge information (if applicable), healthcare service, community programming experiences, LGBTQ aging concerns, and an occupational profile. The occupational profile is an evaluative tool used by occupational therapists to understand habits, roles, routines, and personal interests. Interviews ranged from 45-60 minutes in length and were not recorded. The first author maintained extensive field notes with direct quotations and observations of non-verbal language. While ethnography was not the intentional focus of the study, the first author also conducted observations of activities in which study participants were engaged, gathering further insight about human and non-human contexts.

Data analysis

The project is founded in personal and professional interests stemming from involvement with a county organization’s initiative to increase advocacy efforts with LGBTQ older adult veterans. The data collected were part of a PAR pilot study to determine the need for further investigation. The first author engaged in a process
of comparative analysis, examining each interview with the previous one analyzing the data for repetitions, similarities, and differences.

*Human Subjects Review*

The first author submitted required documents in compliance with university and county agency standards to verify and protect the rights and welfare of the people participating as subjects in the project. The University Institutional Review Board (IRB) determined the study [Registration #059-15] exempt from their jurisdiction.

**Trustworthiness**

Validity, reliability, and credibility are often questioned with qualitative research because data gathering is different than traditional quantitative methods. The first author frequently engaged in debriefing sessions with colleagues, utilized iterative questioning, and established a familiarity with members of the participating culture. These specific methods help to build the trustworthiness of the qualitative data (Shenton, 2004; Srivastava & Hopwood, 2009). In order to remain focused and credible, the first author commonly referred to the following research question during qualitative interview and data analysis, “What is the perspective of older LGBTQ veterans regarding social participation and community engagement?”

**Results**

The first author conducted semi-structured interviews with a purposive sample of seven participants for this pilot study, noted in Table 1, ranging in age from 51 to 87.
Six participants identified as male, one as gender neutral. Education of participants ranged from having a high school diploma to a master’s degree.

[Table 1 here.]

Participant’s stories surrounding community engagement and social participation revealed individual perspectives of lived experience. The first author noted descriptors, words, and behaviors that providing emphasis to the topics under discussion. The first author also conducted field site visits to gain of sense of the human and non-human environments of the county agencies which participants visit. Five common issues pertaining to social participation and community engagement emerged from the data suggesting areas for further action: communal meals, transportation, housing, the coming-out process, and the effect of discrimination, and harassment on mental health.

**Communal meals**

Participant responses indicated the activity of eating is significant for community engagement. Some interviewees stated they don't like to eat alone while others declared that it was an activity they looked forward to every week. Quinn explained, “I'm sort of a loner person. The weekly lunch event helps get me out of the house. Since I'm low-income, it also helps with my food budget.” Some community programs offer the chance for participants to volunteer checking people in, setting up/cleaning up the environment, serving the food, facilitating brief activities during the meal, and making sure attendees feel welcome. “I've seen this meal site change lives,” said Iago, a meal site volunteer for the past six years. “We make a family, a chosen family. I like the families we are able to make.” Meal times offer
opportunities to explore individual roles within the community, contributing to a greater sense of identity and purpose as a member. Author observations corroborate that more participants attended activities involving a communal meal.

Transportation to community events

Participation in public transportation programs was a determining factor for participation in community events. Quinn was the exemplar for the group, rationalizing that he never attends social events at a particular community center far from his home because it would take more than an hour each way traveling via public transit. Author observations within three community service organizations revealed participants used public transportation more than driving private automobiles, supporting the issue as relevant to community participation.

Housing preferences

Each participant described a different current housing circumstance. Three participants lived alone, describing themselves as low-income. Two participants lived with family members, one participant with his life partner, and one in community housing. Three of the seven participants described concerns with finding LGBTQ friendly and inclusive housing as they age. Four of the seven participants also described a lack of knowledge about rights and privileges under the Fair Housing Act and requested more information on this subject.

The coming-out process

The cultural, emotional, and personal significance of disclosing sexual orientation, often referred to as ‘coming-out’, varies across generations. The US military has operated on hetero-normative principles for decades, explaining
why some individuals, particularly elders, experience traumatic situations when they attempt to come-out or remain closeted. Iago described, “I didn’t have the meaning of what it meant to be queer in the military until I was there. I knew I could never be myself there. We older gay people were taught to lie and hide; we don’t always have to do that anymore.” Madigan, a gay man in his late 80’s who served during World War II, expressed, “People assume I’m straight all the time. Even though I’ve been out more than half my life, I don’t always correct them.” Xavier clearly states, “You had to live a secret within the military.” Quinn admits, “Others didn’t need to know I was gay. I never talked about it.” Udell was not out as bisexual during his military service but admits being out now, in his early 80’s, it “helps me be honest with others which leads to a more happy life.”

When considering being out to physicians and healthcare professionals, Hank explained, “Sexuality has never come up during my health care service but I would not be afraid to come out to my physician.” Quinn agrees, “It was not that big of a deal coming out to my physician. I just want to be taken care of. Character is what matters, not sexual orientation.”

_Trauma and mental health_

Participants reported the historical absence of support had negative ramifications. Quinn admitted, “I worked hard in the military, multiple hours per day, to avoid social contact.” While Don states, “I experienced a great deal of culture shock both entering the military and returning to civilian life in my mid-twenties. My alcohol
and drug abuse was no doubt connected to the trauma I experienced in the military.” Don confessed, “I minimized the trauma experienced during the military, it was horrible.” Three individuals, all self-identified females, refused participation in an interview because they claimed their military experience was “too traumatic” to discuss. One in particular claimed, “I never talk about my military experience.”

Valuing community involvement and participating in meaningful social activities Lloyd and Deane (2011) state, “Social networks can also influence engagement in leisure and exercise occupations, thereby benefiting the participants in varied ways, physically, socially, emotionally, and spiritually.” Although individuals have the right to make these claims based on their experience, it creates more questions about how deeply the impact harassment and discrimination has on mental health during the aging process.

**Discussion**

PAR is valuable for involving members of marginalized populations to become determinants of their own health and wellness. Each member of the action research partnership contributes expertise from his or her perspective. Each participant in this pilot study described finding value in involvement in supportive communities. They concurred that participating in meaningful social events has the capability of increasing feelings of purpose and self worth (Howells, 2011). The PAR approach fits the values of professions designed to empower individuals, organizations, and populations for social change.
In order to successfully advocate for change, it is vital for all members of the partnership to appreciate current and past contextual influences. The American Occupational Therapy Association (AOTA) (2014) defines six contexts or environments as influential in daily living: physical, personal, social, cultural, virtual, and temporal. Knowledge of contexts empowers service providers and recipients to make sense of influences on daily life, habits and roles. Knowledge enables PAR partners to name and frame individual and organizational histories, behaviors, expectations, customs, and beliefs. Contexts and environments can support healthy engagement or limit opportunities for participation, as in the case of many elderly LGBTQ veterans. The authors are occupational therapy practitioners, with an identified professional perspective of “achieving health, well-being, and participation in life through engagement in occupation” (AOTA, 2014). Occupational therapists provide client-centered services to individual persons, groups, or populations. The profession is committed to providing a combination of physical, social, and mental health through functional participation in activities that are therapeutically meaningful.

Persons who have experienced traumatic life circumstances or adverse experiences such as violence, war, neglect, war, natural disasters or abuse are at high risk for emotional distress (Substance Abuse and Mental Health Services Administration, 2014; Centers for Disease Control and Prevention, 2014). Blosnich, Dichter, Crulli, Batten, and Bossarte (2014) found that men who enlisted in military service may have done so to escape adverse childhood experiences (ACEs). Men with voluntary
military service were more likely to have high ACE scores than non-servicemen, indicating childhood trauma in addition to service related trauma. Trauma-informed care attempts to build a framework to understand the biopsychosocial effects of traumatic life experiences. The Substance Abuse and Mental Health Services Administration (SAMHSA) developed an approach to trauma-informed care for practitioners, defining the importance of supporting individuals through traumatic experiences. “The desired goal is to build a framework that helps systems ‘talk’ to each other, to understand better connections between trauma and behavioral health issues, and to guide systems to become trauma-informed” (SAMHSA, 2014).

Further research and intervention needs the basic principles of trauma-informed care and a clear PAR approach. PAR has inherent dilemmas. It is necessary to garner buy-in from a variety of partners. von Unger (2012) recommended inclusion of diverse groups, including participants, service organizations, community club members and leaders, professional practitioners and societies, etc. for PAR. The existing snowball system via those who are already included, and can take place step by step during the research process. The PAR approach also educates service providers about issues of concern to marginalized population, supporting increase practice competency.

**Implications**
Contexts support or hinder engagement because they influence the satisfaction, value, and participation of activities. In order to successfully advocate for this population, it is vital to gain understanding of the cultural and social context of senior LGBTQ veterans. Knowledge about these specific contexts will help others understand participant’s histories, acceptable behaviors, expectations, customs, and beliefs. Social participation, community engagement, and context are of concern to all service providers. Occupational therapists are proficient in designing collaboration between participants, care providers and organizations.

Care providers and organizations must recognize U.S. military culture as influential to the experience of LGBTQ senior veterans. Some questions to consider include:

- Did the veteran choose military service or were s/he drafted?
- In what branch of service did s/he engage?
- In what capacity or type of service did s/he engage?
- Did s/he experience LGBTQ-related harassment or discrimination?
- In what location(s) did s/he complete military service?
- During what historical time frame did s/he serve?

Considering the controversial nature of service, care providers and organizations must acknowledge the nuances to appreciate the context.

This research highlights the importance of occupational therapy as a member of the PAR team, especially when considering, “Community development initiatives are
intended to expand the capacity of a community in terms of the knowledge and
skills that are required for the community to survive and thrive” (Letts, 2009).

Issues that emerged during pilot interviews suggest areas for additional
correction. The following recommendations may be helpful to consider in the
next stages of PAR when developing intervention programs:

• Trauma-informed care trainings
• Intergenerational programming
• Discussion panels/workshops
• Outreach to rural communities
• Educating service providers

Limitations
There were several limitations to the study. More than half of participants were
Caucasian (four of the seven). One identified as African American, one identified as
Latino, and one refused to answer questions about racial identity. The small sample
size of mostly Caucasian men may be related to locations where the first author
sought interviewees and basic demographics about the county in which
interviewees reside. It remained difficult to find women and people of color to
interview. Of the three women asked to interview, all declined. The study is limited
to members of one county, within one state.

Conclusion
The purpose of the study was to serve as the first phase of PAR to affect change through critical reflection and to prompt further action research involving members of the community most engaged in the issues. Hank explained, “It is going to be very difficult and challenging to engage people to talk about military service and sexuality.” While the intent of PAR is inclusion of local stakeholders to create change for local communities, it is important to expand the participant profile for changes to be relevant across larger marginalized populations. Occupational therapy practitioners offer an inclusive perspective for PAR, supportive of individuals, organizations, and populations across contexts, valuable in engaging many stakeholders through. Through the change in critical consciousness brought about by the first phase of this work, the first author has been approached by the community to engage in additional solution-seeking activities, including conference presentations, workshop development, and grassroots problem solving across diverse community members. The dynamic nature of this PAR suggests it is time to disturb the silence surrounding LGBTQ elder veterans.
Acknowledgements

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Personally, I would like to thank my grandmother, Alice Proctor. She has taught me I am never too young to try something new. Her compassion and understanding are
qualities that I so deeply admire. My sister-in-law, Amy Jo Proctor, and two nephews, Rigel A. Proctor and Antonin S. Proctor, have reminded me to relax and enjoy life’s small moments. My brother and sister, Ron Proctor Jr. and Angela Proctor, have provided their never-ending love and support throughout my entire educational career. As the youngest sibling in my family, I’m appreciative that I have these two individuals as inspirational role models. My parents, Ron and Tami Proctor, have helped me understand I can do anything I want to do. The confidence they’ve instilled in me is what keeps me asking questions and seeking answers. Lastly, my loving fiancée, Shawn P. Collins, has been a major motivating force throughout this entire graduate school experience. His patience, gentleness, and creativity inspire me to help us construct a more fulfilled life. I’m grateful to be able to experience the aging process with him.
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Table 1. Demographic information for participants.

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