DISSERTATION

EXPLORING STAFF CLINICAL KNOWLEDGE AND PRACTICE WITH LGBT RESIDENTS IN LONG-TERM CARE: A GROUNDED THEORY OF CULTURAL COMPETENCY AND TRAINING NEEDS

Submitted by

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ABSTRACT

EXPLORING STAFF CLINICAL KNOWLEDGE AND PRACTICE WITH LGBT RESIDENTS IN LONG-TERM CARE: A GROUNDED THEORY OF CULTURAL COMPETENCY AND TRAINING NEEDS

Providing culturally competent care to LGBT residents is an important area of concern in the current practice of long-term care (LTC) staff and providers. Existing literature shows that LGBT residents are likely to face discrimination and suboptimal care in LTC facilities due to homophobia, transphobia, and heteronormative/cisnormative policies. This grounded theory study assessed the LGBT cultural competency that exists among staff working in LTC facilities, and provides a framework for understanding how their knowledge, skills, and attitudes with respect to LGBT residents are connected to their ability to care for those populations. The core category identified in this study was "staff sensitivity to minority sexual orientation and gender identity (SOGI) of residents." Main categories reflected the ways that competency, awareness, knowledge, experience with LGBT people, attitudes toward LGBT people, and current training needs reflect staff sensitivity to resident SOGI. Recommendations are made for training LTC staff to be sensitive to the particular needs of sexual and gender minorities in their facilities.

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INTRODUCTION

One of the most compelling and influential demographic shifts in the coming decades will be the so-called "Silver Tsunami," or the increasing proportion of older adults in the United States and abroad. Whereas people age 65 and older currently constitute 13% of the United States population, it is expected that by 2030, approximately one in five people living in the United States will be over the age of 65 (U.S. Census Bureau, 2008). This growth signifies not only an increase of older adults in the general population, but also of diverse groups of older adults. Among these subpopulations are lesbian, gay, bisexual, and transgender (LGBT) older adults. By some estimates, LGBT older adults will range from two to seven million in 20 years, making the need for LGBT-affirmative care all the more critical (Grant et al., 2010).

Like their heterosexual peers, LGBT adults and their loved ones may require additional assistance in taking care of their daily needs as they age, and may face significant challenges in accessing social services, medical care, and other resources necessary for well-being in late life (Addis, Davies, MacBride-Stewart, & Shepherd, 2009; Claes & Moore, 2000). They may find it necessary to access long-term care (LTC) services to obtain additional support due to functional limitations, cognitive impairment, and other health needs (Stone, 2000). However, unlike heterosexual individuals who access LTC services, they often encounter discriminatory and harmful practices based on their sexual identity or gender identity (National Senior Citizens Law Center (NSCLC), 2011). Therefore, it is all the more important that staff and health care providers working in LTC facilities be aware of the particular issues that LGBT residents can face, in order to provide optimal care.

Additionally, the projected growth in the older LGBT population will have a direct impact on LTC staff and health care professionals because they will have a greater likelihood of encountering LGBT individuals in their work. In response, staff and providers will need to work using a more nuanced understanding of older adulthood and the ways that residents' sexual identities, gender identities, and life histories impact health care access and service delivery (Karel, Gatz, & Smyer, 2012).

The present study assessed the current level of LGBT cultural competency that exists among staff and providers working in LTC facilities. To date, little research has been done on LGBT cultural competency and LTC settings, and this project was intended to build upon what is currently known about cultural competency with LGBT people of all ages, as well as what is known about the current level of cultural competency among aging services providers. The framework that emerged from this study will be useful in making further recommendations, such as how to implement LGBT cultural competency training that is relevant to the LTC setting, in hopes of increasing competent service delivery to LGBT residents.

LGBT Health Care Disparities and Barriers to Long-Term Care

A first step toward providing adequate and competent care to LGBT individuals is acknowledging the health disparities that exist between LGBT and non-LGBT people, and examining the existing barriers to quality health care. Health disparities among LGBT people are well documented, and range from negative effects of stigmatization to reduced access to health care services (Dean et al., 2000). Barriers to health care are typically described at the institutional level, the patient level, and the provider level (Hernandez & Fultz, 2006; Geiger, 2006).

Institutional-level barriers include laws and policies that limit benefits and legal protections for LGBT individuals and same-sex couples particularly in the context of advanced health care planning and end-of-life care (Hernandez & Fultz, 2006). They may also include the attitudes of nonclinical facility staff, limited appointment availability and duration, and excessive patient loads (Geiger, 2006; Hernandez & Fultz, 2006). When asked what constitutes a culturally competent environment, both health care providers and LGBT residents have identified structural components (e.g., gender-inclusive bathrooms) and systemic factors (e.g., using intake forms that do not rely on heteronormative or binary gender assumptions) as important parts of LGBT cultural competency. In addition, providing cues that indicate an LGBT-affirming stance can enhance the provider-patient relationship (Wilkerson, Rybicki, Barber, and Smolenski, 2011).

Patient-level barriers to care include fear of discrimination in health care settings, beliefs about medical care, and their level of trust toward health care providers (Geiger, 2006; Hernandez & Fultz, 2006). Because older LGBT people are less likely to rely on their family of origin for caregiving needs and support, many must seek LTC in community-based or institutional facilities (SAGE, 2010). Accessing LTC services presents some unique issues for LGBT older adults that their heterosexual counterparts do not encounter (Shankle, Maxwell, Katzman, & Landers, 2003). For example, older LGBT adults report that they fear discrimination in health care settings (Jackson, Johnson, & Roberts, 2008; Quam & Whitford, 1992). LGBT residents who have been "out" for a large portion of their lives may go "back in the closet," fearing mistreatment and denial of care if they were to be open about their identities and relationships (Brotman, Ryan, & Cormier, 2003; Grant et al., 2010; Johnson, Jackson, Arnette, & Koffman, 2005; NSCLC, 2011; Shankle et al., 2003; Stein, Beckerman, & Sherman,

2010). In fact, up to one-third of older LGBT people have reported they are willing to hide their sexual orientation (Johnson et al., 2005). This has negative consequences for both physical and mental health, as non-disclosure of sexual orientation negatively correlates with the quality of health care services provided (Stein & Bonuck, 2001). LGBT people may not seek services because they fear mistreatment, or they may conceal their sexual orientation in order to avoid discriminatory practices. Regarding the patient-provider relationship, there is evidence that lesbians may have a more difficult time disclosing their sexual orientation to their doctors than gay men, and that they are less comfortable talking about sexuality (Klitzman & Greenberg, 2002). In addition, older white males feel more comfortable disclosing to their doctor, discussing sexuality, and seeking out LGBT-affirmative providers, whereas female, transgender, and non-White patients appear to face considerable obstacles in accessing competent and quality care (Klitzman & Greenberg, 2002).

Finally, provider-level barriers include the biases, stereotypes, misinformation, and homophobia that health care professionals may possess when providing services to LGBT individuals (Bonvicini & Perlin, 2003; Hernandez & Fultz, 2006). Lack of cultural competence with LGBT patients is one of the greatest factors in health care disparities between LGBT and non-LGBT populations (Geiger, 2006). Components of cultural competence include the attitudes of health care providers toward LGBT people, their medical training in LGBT-relevant issues, their clinical skill and confidence (i.e., being able to discuss sexuality with patients), and avoiding incorrect assumptions about LGBT patients (Bonvicini & Perlin, 2003; Geiger, 2006).

Even when administrators and direct service staff indicate that they are comfortable serving LGBT people and believe in the importance of providing them with affirming, high-quality care, they may also have little knowledge of LGBT-specific health concerns, and few

agencies actually implement policies and programs that specifically target LGBT older adults (Hughes, Harold, & Boyer, 2011). Indeed, research has identified a "systematic negligence" of LGBT individuals, in which culturally competent care is not prioritized, leaving LGBT people with little recourse for high-quality care (Hughes et al., 2011). This discrepancy is notable, as it points to some providers being more accepting and welcoming to LGBT people, but lacking the ability to adequately address their needs.

Homophobia and Heterosexism in Long-Term Care

Studies on LGBT access to health care and social services have also documented evidence of heterosexist discrimination and homophobia toward LGBT individuals in LTC facilities (Brotman, Ryan & Cormier, 2003; Cahill et al., 2000; Claes & Moore, 2000; Cook-Daniels, 1997; Hash & Cramer, 2005; National Senior Citizens Law Center, 2011; Quam & Whitford, 1992). Homophobia is defined as "feeling[s] or actions based on hatred, aversion or fear of same-sex attraction and sexual behavior among lesbian, gay or bisexual people" (Grant et al., 2010, p. 13). Heterosexism refers to the worldview and value system that privileges heterosexuality over other forms of sexual expression, including bisexuality and homosexuality (Herek, 1986). Homophobic behavior in LTC settings might include verbal and physical harassment by facility staff, discriminatory admission or discharge, and denial of services like bathing and basic hygiene (Johnson et al, 2005; NSCLC, 2011). Individuals who are partnered may be denied visits by their partner, or may be mocked by residents or staff (Hash & Cramer, 2005).

Overall, LTC staff persons have been shown to have more negative views toward same-sex sexual behavior in a facility than toward heterosexual behavior, with particularly negative attitudes toward gay men (Hinrichs & Vacha-Haase, 2010). A recent review of nursing attitudes

toward LGBT patients revealed that the majority of nurses have unfavorable attitudes toward LGBT patients, which has a negative impact on service-delivery and patient care (Dorsen, 2012). Other results show that less than 25% of health service directors in nursing homes reported receiving training on homophobic health care practices within the previous five years (Bell, Bern-Klug, Kramer, & Saunders, 2010). These findings are concerning, as they represent a significant barrier to receiving competent care, and underscore the importance of addressing the attitudes and competencies of LTC health care providers and staff members.

Biphobia

Discussions of sexual identity typically use a heterosexual/homosexual binary, but recent survey data have pointed to the experiences of bisexual-identified people being somewhat different from those of gay and lesbian-identified individuals. Bisexual individuals are less likely to be "out," to have supportive families, and to view their sexual identity as an important part of their self-identity (MetLife, 2010; Rodriguez Rust, 2012). These experiences of bisexual individuals are important to include as part of a culturally competent understanding of non-heterosexual people. Bisexual people are not only subject to heteronormativity and homophobia like other non-heterosexuals, but also experience prejudice among gay and lesbian people (Israel & Mohr, 2004). Biphobic attitudes could just as likely exist in a LTC context as any other, and could negatively impact the care of bisexual residents.

Transphobia

Transphobia refers to feelings of fear, aversion, or hostility directed toward transgender or gender-nonconforming individuals, typically by cisgender (non-transgender) individuals (Hanssmann, Morrison, & Russian, 2008). Fear of transphobic reactions from health care providers remains a significant barrier to transgender patients of all ages. However, older

transgender adults face challenges on institutional, systemic, and health-related levels that result in significant health disparities (Cook-Daniels, 2007). As compared to both heterosexual and LGB individuals, transgender older adults are less likely to have health insurance coverage, more likely to have experienced harassment or abuse in a health care setting, and less likely to seek care due to their fear of discrimination (NSCLC, 2011). Even well intentioned staff may create uncomfortable situations for transgender residents due to cisnormative assumptions, such as bringing the wrong bedpan or not using the residents' preferred name or gender pronouns (NSCLC, 2011). Mistreatment, or even oversight, can cause significant harm in the patient-provider relationship and can impede caring for transgender residents.

Cultural Competency with LGBT Residents

An antidote for the negative experiences of LGBT people in LTC settings is increased awareness on the part of health care providers and facility staff of the needs and concerns that are particular to LGBT residents. Such awareness and knowledge are thought to reduce the influences of homophobia, transphobia, and heterosexism in facilities that serve an increasing number of LGBT individuals (Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emlet, & Hooyman, 2014; Turner, Wilson, & Shirah, 2006). Literature on health care needs of older LGBT people has consistently identified LGBT-affirmative and culturally competent care as a priority (Brotman et al., 2003; Claes, 2000). Although the preponderance of the literature focuses on racial and ethnic cultural competency, LGBT cultural competency is another important aspect of health care providers' work with diverse populations (Turner et al., 2006).

Cultural competence has emerged as an important characteristic of helping professions, usually with an emphasis on better serving underserved or marginalized populations. At its core, cultural competence in health care is generally understood as "the ability of systems to provide

care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs" (Betancourt et al., 2002, p. 3). Furthermore, cultural competency is defined as health care providers possessing the knowledge, attitudes, and skills that are necessary to work with diverse patient populations (Turner et al., 2006; Van Den Bergh & Crisp, 2014). Culturally competent care can be implemented at organizational, systemic, and clinical practice levels (Betancourt et al., 2002). For health care providers, this often includes an understanding of the cultural, economic, and interpersonal context of the people seeking care, as well as awareness of assumptions and biases on the part of the providers (Yali & Revenson, 2004).

In regards to services oriented to older adults, the existing literature suggests that only a fraction of agencies in a given city are likely to have policies and procedures that are sensitive to sexual and gender minorities' needs (Anetzberger, Ishler, Mostade, & Blair, 2004; Portz et al., 2014). This may include offering gender-inclusive paperwork, providing domestic partnership benefits for LGBT employees, and providing staff with training on LGBT patient needs.

LGBT Cultural Competency Training in Long-Term Care

The literature on LGBT cultural competency in LTC settings is still in an exploratory stage, which may be due to many LTC facilities' relatively recent awareness of LGBT people. Currently, formal education and training in serving LGBT patients appears to be sparse and inadequate. A survey of nursing and medical students' knowledge of LGBT residents' medical and mental health needs revealed that only a small fraction of students (10%) had a "passing" knowledge of how to care for LGBT people (Rondahl, 2009). A survey of Area Agency on Aging executive directors showed that 20% of agencies sampled had offered LGBT-oriented training to their staff, but that 75% of them would be willing to offer such trainings (Knochel,

Quam, & Croghan, 2011). These results highlight the need for more direct and high-quality education of health care professionals regarding the psychological needs, health care needs, and lives of LGBT people. This is particularly important given the relative invisibility of older LGBT people in geriatric care (Butler, 2004; Hash & Cramer, 2003).

The results of community and provider-focused dialogues on LGBT cultural competency that have occurred are encouraging. Some communities have sought to create dialogues, workshops, and trainings focused on increasing LGBT cultural competency among health care service providers. Follow-up on one such project revealed that two-thirds of participants took steps to educate themselves about older LGBT adults and take actions to improve the quality of care in health care and social services facilities (Anetzberger et al., 2004). In another program that focused on educating health care providers about transgender issues and health needs, participants proactively created their own action plans within their agencies to move toward a more culturally competent model of care that better served the needs of transgender and gender-nonconforming people (Hanssmann et al., 2008). Although each of these studies has made a contribution toward understanding methods for increasing providers' ability to effectively work with LGBT residents, none of them has specifically focused on the LTC context.

With respect to LGBT competency training needs among LTC providers and staff, there is little directly related to the LTC setting. One exploration asked aging services providers if they wanted training, what kind of training modality they preferred, and what topics they would like to have covered (Hughes et al., 2011). Results showed that two-thirds of aging services providers desired training in a range of LGBT- and aging-related topics, mostly preferring in-service or online modalities. It may be that existing knowledge about LTC staff and providers' ability to serve LGBT people can be extrapolated from existing literature about aging services

providers in general, but there is currently no research on LTC staff members' self-assessment of cultural competency with LGBT residents; nor is there any research on provider-identified areas of knowledge and practice with LGBT residents in which they feel they could benefit from further training.

LGBT Cultural Competency Framework

An example of a model for health care providers' cultural competency with LGBT patients is the LGBT Cultural Competency Framework for Public Health Practitioners (Turner et al., 2006). This framework focuses on providers' knowledge, attitudes, and skills as they relate to serving LGBT patients, and assumes a general process of progression from knowledge (awareness), to attitudes (sensitivity), to skills (competency), and finally to mastery (ability to train others). These components can be applied to a variety of topic areas, which include stigma, inclusion, terminology, roles and family structures, sociopolitical factors, access to care, quality of care, and personal values, among others. The authors assert that the framework "serves as a basis for achieving general LGBT cultural competency and can be used as a guide for developing LGBT cultural competency training materials and curricula" (Turner et al., 2006, p. 68). This framework assumes that individuals are located somewhere along the continuum of LGBT cultural competency, depending on their existing knowledge, attitudes, and skills for working with LGBT people. Although designed for general public health practitioners, this framework also appears useful and appropriate in a LTC context.

Awareness. This component constitutes the knowledge that LGBT people exist in diverse settings, and that they are themselves a diverse group. It also includes individuals' knowledge of sexual identity and gender identity constructs, and the terminology used by LGBT individuals to describe themselves and their experiences (Turner et al., 2006; Van Den Bergh &

Crisp, 2014). Awareness is also a form of self-knowledge, as health care providers may or may not be aware of their own personal biases, prejudices, and assumptions about LGBT people. Finally, culturally competent providers possess knowledge of various factors that directly impact LGBT health and well-being, including the effects of stigma and discrimination (Dean et al., 2000, Turner et al., 2006; Van Den Bergh & Crisp, 2014).

Sensitivity. The sensitivity component of this framework focuses on developing an attitude of empathy for the experience of LGBT people. This is characterized by providers beginning "to distance themselves from a heteronormative perspective, in which the existence of LGBT people, clients, and peers is not recognized or valued," and gaining "appreciation for and validation of diversity in sex and gender orientations and identities" (Turner et al., 2006, p. 70). This also includes appreciation of the impact that sociopolitical factors (e.g., the effects of federal restrictions on marriage for same-sex couples), have on LGBT people (Van Den Bergh & Crisp, 2014).

Competency. The next stage in the framework addresses the behaviors that health care providers perform to demonstrate advocacy and active support for LGBT patients and their rights as health care recipients. This might include developing LGBT-sensitive policies and paperwork in an agency that serves older adults, or practicing non-discriminatory communication styles with patients (Turner et al., 2006; Van Den Bergh & Crisp, 2014).

The LGBT Cultural Competency Framework described above was designed for public health practitioners from diverse disciplines, working in a wide range of health care settings (Turner et al, 2006). It is a useful model for developing training materials as well as research questions. Indeed, the authors stated that "LGBT competencies need to be further developed and tailored for specific public health disciplines" (Turner et al., 2006, p. 79). This is certainly true

in the case of LTC facilities, where professionals and staff with different roles and diverse training backgrounds come together to serve residents. It is evident from research on LGBT health disparities in LTC that more work is needed to close the gaps which continue to exist in providers' knowledge, attitudes, and skills with LGBT residents (Dean et al., 2000; Van Den Bergh & Crisp, 2014). In order to promote growth in providers' cultural competence, it is necessary to understand the current level of LGBT cultural competence among LTC providers, as well as how they feel they could increase their level of competency.

Present Study

The purpose of this study was to explore the ways that LTC staff members understand their knowledge, attitudes, and skills in their practice with LGBT residents, to identify areas that further training should address with regards to serving LGBT residents, and to develop a framework for understanding LGBT cultural competency among LTC staff and providers. The following questions guided the inquiry of this study:

1. How do LTC staff assess their current knowledge with regard to LGBT residents?
2. How do LTC staff assess their current attitudes toward LGBT residents?
3. How do LTC staff assess their current skill in interacting with and providing health services to LGBT residents?
4. How do LTC staff believe they could grow in their knowledge, attitudes, and skills with regard to providing services to LGBT residents in their facilities?

For this study, grounded theory was selected as an appropriate method to explore these questions. Unlike other qualitative methods whose intent is to describe a phenomenon or understand an experience, grounded theory seeks to understand an action, process or interaction, leading to the development of an applied theory for understanding and explaining the topic of

study that is "grounded" in the research data (Strauss & Corbin, 2008). In this type of study, data are concurrently collected and analyzed, allowing for emerging themes and categories to guide further investigation. The outcome of this study was a theoretical framework for LGBT cultural competency that took into account the current knowledge, skills, attitudes, and training needs of LTC staff and providers.

METHOD

Research Setting

Long-term care can be difficult to define, as it occurs in a wide range of settings and includes a spectrum of services. LTC settings can range from a person's own home, to residential care settings such as adult day care and assisted living facilities, to institutional settings such as nursing facilities, psychiatric hospitals, and LTC hospitals (Stone, 2000). For the purposes of this study, LTC facilities that provided skilled-nursing care, dementia care, and palliative care were considered. Facilities that were primarily concerned with rehabilitation services and assisted living communities were excluded from participation in this study. Staff from three LTC facilities in the Denver Metro/Front Range areas of Colorado participated in this project.

Facility 1 was a 93-bed, privately-owned memory care clinic, accepting both Medicare and Medicaid insurance. Services provided at the facility include 24-hour skilled nursing care, cognitive rehabilitation, respite care, and hospice and palliative care. Facility 2 was a 60-bed, for-profit LTC and rehabilitation facility, which accepts Medicare and Medicaid residents. Services provided include short-term rehabilitation, respite care, long-term skilled nursing care, and dementia care. Facility 3 was a 135-bed, non-profit continuum-of-care LTC facility, which accepted Medicaid and Medicare as well as private insurance. The facility had a self-stated mission of serving underserved populations, including gender and sexual minorities. Facility 3 was a state-of-the-art facility featuring a wellness center, 24-hour skilled nursing care, rehabilitation services, and counseling services for residents and families.

Participants

Twenty-two staff members from three facilities were recruited for this study, representing a diversity of disciplines, training backgrounds, and LTC work experience (see Table 1 for complete demographic information). Participants' age ranged from 22 to 72 (M = 45.68, SD = 13.25). Nineteen participants self-identified as female, and three participants self-identified as male, with no participants identifying as transgender (MTF or FTM). One participant self-identified as lesbian, and all others self-identified as heterosexual. They represented a range of racial and ethnic identities, including Hispanic/Mexican American, African American, Native American, Asian American, and Multi-Racial identities, with a majority (n = 14) identifying as European American. Regarding religious orientation, participants endorsed affiliation with a range of Christian denominations, as well as Buddhist and Jewish affiliations. Nine individuals did not indicate a religious orientation. Participants represented a diversity of positions in their facilities, including social workers, CNAs, nurses, executive directors, janitorial staff, and administrative staff. They reported educational attainment ranging from a high school diploma or GED to graduate or professional degrees. Finally, staff reported a wide range of work experience in LTC settings, and in their present facility. The time staff members had worked in LTC ranged from 10 months to 28 years (M = 12.90, SD = 7.23), and the time they had worked in their current facility ranged from 5 months to 15 years (M = 4.25, SD = 3.60).

Researchers

The primary researcher (Weston Donaldson) is a 29 year-old, self-identified European-American gay male who is a doctoral student in counseling psychology. He initially became interested in issues related to older LGBT adults after attending a training that discussed the challenges faced by that population, particularly in LTC settings. Furthermore, a research team

that includes other counseling psychology doctoral students interested in research of older adult issues, as well as a licensed psychologist specializing in geropsychology, aided in project development, providing consultation and feedback, and analyzing data.

Research Paradigm

The primary researcher approached the current study from an interpretive-constructivist paradigm. By using this paradigm, the researcher acknowledged the researcher-as-interpreter role in this type of grounded theory study. With this came the assumption that data were interpreted through the lens of the researcher's own experiences, biases, and beliefs. Therefore, interpretive research is not concerned with discovering some sort of objective reality, but instead attempts to describe observed phenomena through the interpretive lens of the investigator. The researcher also held a strong constructivist value, and was interested in the socially constructed ideas and institutions that impact all people. This means that he approached the research questions on gender, sexual orientation, and LTC with the belief that those constructs have been created by society, and are therefore subjective and contextual. The resulting theory was assumed to have been co-constructed by the interactions between participants and the researcher, as interpreted through his particular worldview and experience. The ultimate goal of this project, from the interpretive-constructivist paradigm, was not to know the absolute reality or truth related to the research topic, but to know more deeply how the phenomenon of LGBT cultural competency was actually experienced and constructed by LTC staff in a variety of contexts.

Data Collection

Initially, the researcher intended to collect data using two modalities: focused group discussions and semi-structured individual interviews. However, when the researcher contacted participants to participate in follow-up interviews after focus groups were completed, only one

participant responded. Given that, the researcher opted to use only the focus group modality for collecting data. Focus groups have been shown to be an effective way to collect qualitative data, as they afford a unique opportunity to gather not only participants' individual reactions and opinions, but also the collective group experience and reactions to the research topic (Halcomb, Gholizadeh, DiGiacomo, Phillips, & Davidson, 2007). The interactional component of focused group discussions allows for greater richness and a different kind of depth that is not accessed by individual interviews (Krueger & Casey, 2009).

Focus Groups

Four focus groups were conducted at three LTC facilities between February and May 2014. Group discussions were facilitated by the researcher, and lasted 45-60 minutes each. To guide the discussions, the researcher used a questioning route based on the research questions, while also keeping existing theoretical frameworks and literature in mind (see Appendix B). A questioning route is a written schedule of open-ended questions that includes an opening question, introductory questions, transition questions, key questions, and an ending question (Krueger & Casey, 2009). This series of questions allowed the researcher to ask generally about the topic (e.g., LGBT cultural competency) before focusing directly on the specific constructs of interest (e.g., knowledge, skills, and attitudes). Focus group discussions were audio recorded, and then transcribed verbatim in order to preserve the authenticity of the exchange and allow for thorough data analysis.

As data analysis began to reveal some of the codes and categories reflected in the first two focus groups, the researcher modified the questioning route before the third and fourth focus groups to reflect areas that needed further exploration, or areas that appeared missing in the data (see Appendix C for the final version of the revised questioning route).

Brief Self-Assessment

Prior to engaging in the focus groups, participants responded to the following three self-assessment questions on the demographic sheet, which they rated on a 5-point Likert scale:

- How much do you know about LGBT people in general?
- How would you describe your feelings toward LGBT people?
- To what extent do you rate your ability to work with LGBT residents in your facility?

The intention of asking these questions before the focus group discussions was to get an idea of how staff members viewed themselves before engaging on the topic with their peers. See Table 1 for results of the brief self-assessment, and Appendix A for the demographic sheet that includes the questions and Likert scale anchors.

Sampling Procedures

The researcher initially contacted 11 LTC facilities in the Front Range/Denver metro area of Colorado, first by email and then by letter. He described the research topic and project parameters, and asked executive directors if the facility staff would be open to participating. Two additional facilities were contacted through mutual connections between the researcher, his faculty advisor, and LTC staff in those facilities. Three facilities responded to the researcher's outreach attempts, and consented to allow the researcher to speak with their staff members for the project.

After initial contact with each participating facility, the researcher met with social workers (Facilities 1 and 2) or the executive director (Facility 3) to organize recruitment to the study. These individuals advertised the project with materials provided by the researcher, and invited staff to join the focus groups at scheduled times. Six participants participated in the first focus group, two in the second, nine in the third, and five in the fourth and final group. For the

purposes of this study, attention was paid to demographic characteristics of the participants including age, gender, race/ethnicity, and sexual orientation, as well as particular characteristics such as time working in LTC and duration of employment in the current LTC facility (see Appendix A and Table 1). Typical sample sizes for a study of this type are in the range of 20-30 participants, which usually yields enough information without being redundant (Creswell, 2007).

Initially, participants were selected using purposive sampling, meaning that they were selected based on their relevance to the research questions. For this study, all staff working in a LTC facility could have been included in this study as participants. However, non-English-speaking individuals may not have been able to participate in focus groups due to language barriers, and so may have been excluded from the study.

Following the initial collection of data, additional participants were selected and follow-up questions were created using theoretical sampling, meaning that they were selected based on the categories emerging from the data. For example, the researcher was mindful of the types of participants in the study, and asked the staff helping with recruitment to select a diverse group of participants for the focus groups. When it was clear that most participants endorsed favorable attitudes toward LGBT people, the researcher specifically asked for participants who had less favorable attitudes, although this did not result in recruiting such individuals. When using theoretical sampling, the data analysis guides the researcher to deepen understanding of existing categories and explore connections between categories, ultimately leading to the applied theory that explains the process in question (Strauss & Corbin, 2008).

Data Analysis

Data from focus groups and individual interviews were audio-recorded, transcribed, and then analyzed using a constant comparison method that is common in grounded theory studies

(Creswell, 2007). The researcher then analyzed the data using three levels of coding, with each level illustrating a broader theme or category related to the topic of study. Data collection occurred concurrently with the coding of data, as emerging themes and categories required further exploration and additional data collection. Data collection ended when the data analysis revealed no new information in regards to the research questions, and therefore reflected a theoretical saturation of the research topic.

Open Coding

This was the first step in data analysis, where the investigator created initial categories of the collected information. This also included sub-categories that reflected different components of the main categories, particularly as they related to different dimensions or extremes of the categories (Creswell, 2007). At this stage of analysis, the researcher drew small units of meaning from the transcribed text, labeled them, and then checked them against the existing data in order to ascertain their relevance and "groundedness" in the text (Fassinger, 2005). Strauss and Corbin (2008) also refer to this process as "microanalysis," which is viewed as being particularly effective in earlier research phases because it ensures that the researcher does not miss nuances in the data that could be important in later phases. Even so, the researcher employed this method with all data to ensure grounding in the data and a thorough understanding of what participants said in the group discussions. Open codes included, at times, verbatim statements or clauses from participants, while at other times they were the researcher's initial summary of what participants said. For example, Participant 1 said, "Oh yeah well I worked in a hospital back in New York in the early 90's. And with the AIDS when that was just all coming about, and we had quite a few gay patients and I didn't notice that anyone treated them any different." This was initially coded with open codes "participant's previous experience working

with gay patients in AIDS crisis" and "participant did not notice anyone treating gay pts differently." Although the researcher was aware of broader constructs and research literature related to the research questions, he attempted to balance that with what was directly stated in the text, so as to have open codes that were only one level removed from the data.

Axial Coding

The next phase of data analysis involved labeling units of meaning identified in the open coding phase and grouping them into broader categories, and beginning to identify the relationships between those categories (Fassinger, 2005). During this process, the researcher often referred back to the text to ensure that axial codes and emerging categories were reflective of what had been said by participants, and codes were constantly re-organized and re-labeled to better fit what emerged as the analysis continued. In the example from the preceding paragraph, the researcher moved up another level of abstraction by placing the open code "participant's previous experience working with gay patients in AIDS crisis" into a broader axial code of "past experience caring for LGBT patients." Similarly, the open code "participant did not notice anyone treating gay pts differently" was coded "no experience with LGBT people being treated differently." As illustrated by this example, analysis moved from the statements of participants, to basic units of meaning, to more abstract labels and categories of meaning.

Selective Coding

During the final stage of analysis, the researcher moved toward theoretical integration of existing categories, and examined codes for evidence of the connections between categories. Continuing the examples from above, the researcher took the axial code "past experience caring for LGBT patients" and grouped it with other axial codes related to participants' experience with LGBT people. In turn, this group of codes became the main category "Experience with LGBT

People" that contained participants' experiences, both personal and professional, with LGBT people. In the same way, the axial code "no experience with LGBT people being treated differently" was included in a category that eventually became "Awareness of LGBT Residents' Challenges," as it represented a lack of awareness of challenges faced by LGBT people in health care settings.

The ultimate goal of this phase of coding was to identify a core category that applied to all categories and integrated the information into an explanatory tool (Strauss & Corbin, 2008). This may be a hypothetical model, based on the observations made of the data and the apparent relationships between categories. The model may be as narrow or as broad as the investigator desires, to the point that it includes interpretation from the cultural context in which the central phenomenon exists (Creswell, 2007). Thus, the product of this grounded theory study was a substantive theory that addressed the research questions and proposed ways to address the problem, study the phenomenon further, or provide guidelines for further action (Creswell, 2007; Fassinger, 2005). In this phase, the researcher made use of diagrams to begin naming the connections between categories, and journaled about his impressions and reactions as part of the process of identifying the core category. This process involved constant referral to transcripts, open codes, and axial codes, resulting in revision of categories and restructuring of the developing theory to better fit the data. At the same time, the researcher kept in mind the constructs that have been identified as being related to culturally competent practice, such as sensitivity, awareness, knowledge, attitudes, and skills. For example, research has identified connections between experience with LGBT people and attitudes, and the researcher checked the data for that connection to ensure that it was validated by the analysis in this study. In essence,

he drew bidirectionally from the data and from broader research-based concepts to construct the theory that was the outcome of the present study.

Saturation

The term saturation refers to the point in qualitative data collection and analysis when no new information, properties, or dimensions are gained as more data are collected (Creswell, 2007; Strauss & Corbin, 2008). Data are alternately collected and analyzed in a recursive process that allows analyzed data to influence further data collection. Once collected data appear to be redundant and no longer provide further information on a category, the collection process may focus on another category, or on a conceptual relationship between categories. When all categories and their relationships appear to be saturated, then data collection is said to be finished. For the present study, this meant that focus groups were carried out until the study reached the point of saturation (Bowen, 2008). For research projects using focus groups, it is recommended to conduct three to four groups and then analyze the data to check for saturation (Krueger & Casey, 2009). In this study, there was enough time between data collection periods that the researcher was able to adequately analyze the data from the first two focus groups before conducting the third, and again before the fourth. Because of this, the researcher was able to tailor questions to develop categories more deeply and explore connections between categories. By the fourth focus group, it appeared that although participants were demonstrating variability within the existing categories, no new main categories emerged that were related to the research questions. Instead, participants in the fourth group seemed to confirm impressions that the researcher had from previous groups, thus indicating that saturation had been achieved. This was confirmed upon open and axial coding of the fourth focus group transcript.

Trustworthiness

Trustworthiness is the means whereby the validity and transferability of qualitative research is achieved. Typically, researchers employ several approaches to ensure that the design of the study, the data collected, and the conclusions drawn from the data are in keeping with rigorous research methods and data-driven interpretations (Creswell, 2007). This is particularly important for grounded theory research, which is designed to generate conclusions that clearly emerge from the data. For the present study, several approaches were used to ensure the trustworthiness and transferability of the results.

*Reflexivity***.** In order to be mindful of the researcher-as-instrument component of qualitative research, it was important that the researcher document decisions about method and study design, entry into the research site, reactions to the data collection process, conclusions drawn from data analysis, and changes made to the study resulting from data analysis. This element of self-reflection also acknowledged the researcher's own role in interpretation of the results, especially as they may have been influenced by his biases, beliefs, underlying assumptions, and identities (Creswell, 2007; Morrow, 2005). For this study, the researcher employed a process called *memoing* to document all of his decisions, reactions, questions, and interpretations of data in order to maintain awareness of his role (Strauss & Corbin, 2008). The memo writing process helped the researcher document his ideas about the theory as it emerged from the data during each stage of coding (Creswell, 2007). All memos eventually became part of the data record, and were included as part of the "story" the research created (Fassinger, 2005).

Keeping memos also allowed the researcher to document when his underlying assumptions were challenged or confirmed. At the outset of the study, the researcher assumed

that participants would show a range of attitudes, levels of knowledge, and degrees of awareness with respect to LGBT residents. For example, he expected to hear more about gay and lesbian residents, and less about bisexual and transgender residents. This was confirmed in the case of LGB residents, but the researcher was surprised to hear participants' interest and experiences with transgender residents.

Auditing. Similar to memoing, auditing is the way that qualitative researchers keep a "paper trail" to maintain awareness of bias and the researcher's interpretive lens (Fassinger, 2005). Therefore, the researcher sought the advice, feedback, and constructive criticism of a peer reviewer as well as a counseling psychology faculty member. The purpose of consulting was to generate alternative hypotheses, increase awareness of researcher bias, and assure the quality of the research design as it evolved. A peer reviewer examined the transcripts, along with open and axial codes, to ensure that emerging categories were grounded in the data. This peer reviewer is a 28-year-old biracial Black/White heterosexual woman with knowledge in qualitative research and interest in LGBT advocacy. She provided alternative perspectives and interpretations of some memos, and responded to the researcher's questions with ideas for further exploration. The reviewer gave feedback about the researcher's methodological considerations, and confirmed that saturation had been achieved by the final focus group. Overall, the auditing process allowed the researcher to feel confident that he maintained awareness of his personal biases, while also developing an applied theory that was grounded in the data.

Thick and rich description. All focus group discussions and individual interviews were audio-recorded, and then transcribed verbatim. When transcribing data, the researcher made sure to include a thick description of the participants' words and context, including non-verbal cues and emotional expressions, which improved the reliability of the data (Creswell, 2007). Thick

and rich description allows readers to make their own interpretations and connections with the data, thus enhancing the transferability of the results to other contexts or populations (Creswell, 2007).

Member checking. During the data collection process, the researcher often summarized what participants said in the group discussions to make sure he understood them, and to clear up any misinterpretation. Later, focus group participants were given the opportunity to "check" the accuracy of transcribed data. The researcher provided participants with transcribed focus group discussions, and asked them to indicate any inaccuracies, make any clarifications, or add any information that came to mind following the focus group. Only one participant responded to this offer, and asked the researcher to revise information that could identify the facility. The researcher made the suggested changes and confirmed them with that participant. This process has been successfully employed in other grounded theory studies, and ensures the quality and the transferability of the research conclusions.

RESULTS

Results include data obtained from participants via the participant demographic form (Appendix A), where they provided an assessment of their knowledge, skills, and attitudes with respect to working with LGBT LTC residents (see Table 2). Qualitative analysis of focus group discussions revealed one core category and eight main categories that described and explained the components of LGBT cultural competency among the study participants (see Table 3 for a list of all main categories and subcategories).

Staff Self-Assessment

When completing demographic information, participants were asked to rate their knowledge, skill, and attitude with respect to LGBT people on a 5-point Likert scale. The questions to which they responded are the following:

- How much do you know about LGBT people in general?
- How would you describe your feelings toward LGBT people?
- To what extent do you rate your ability to work with LGBT residents in your facility?

The results of this brief self-assessment are found in Table 2. Although this is a qualitative study, the researcher included this component as a way to know how participants rated themselves on the topic of study before discussing it with other participants. Overall, participants indicated that they had "some knowledge" of LGBT people, and had "neutral" feelings about LGBT people. However, all but two participants rated themselves "completely able" to work with LGBT residents. Implications of these responses, as well as comparisons with qualitative data, will be explored in more detail in the discussion section.

Core Category: LTC Staff Sensitivity to Minority SOGI of Residents

Analysis of the data seemed to point to one overarching theme, which appeared to be the core category that was related to LTC staff working with LGBT residents. The core category was labeled "staff sensitivity to minority sexual orientation and gender identity (SOGI) of residents," and appeared to explain the process of culturally competent knowledge, attitudes, and behavior of LTC staff when working with LGBT residents. For a visual representation of the way the core category is connected with the main categories, see Figure 1.

The core category of "staff sensitivity to minority SOGI of LTC residents" seemed to be an appropriate explanatory concept for the data for several reasons. First, the term "sensitivity" was broad enough to capture the range of responses staff seemed to have to LGBT residents. As will be seen, there appeared to be major tensions among staff over how to approach sexual and gender minorities in their facilities. As a result, staff demonstrated a possible lack of sensitivity, or ambivalence about their sensitivity to LGBT residents. Certainly, some participants indicated that they would be very sensitive to LGBT residents. This concept was reflected in all main categories, and appeared related to all other major components of the data.

This core category was drawn from two main themes that appeared somewhat antithetical, which explained the observed tension among staff when trying to articulate how they might respond to sexual and gender minorities in their facilities. The tension, as drawn from the data and observation, surrounded LTC staff members' desire to treat LGBT residents the same as all other residents. There was one particular moment in the third focus group where the tension of this issue flared into arguing and defensiveness among participants. I believe that it was at that time when, without knowing it, I identified the core category. When responding to the conflict, I said:

> So my goal is really to understand, you know, so I think it's great that we have different perspectives and different experiences, (laughter) so I think it's an important thing. There's this concern about, seems like we're struggling with how do we take care of a group that might have special particular needs, but without being unprofessional or showing some favoritism, and yet acknowledging the sigma that a person might have based on that. I think we're all trying to figure this out. How do we balance that?

The tension seemed to exist between the approaches of "treating all residents the same" and "not treating all residents the same," which seemed to be a variation on the theme of sensitivity. Participants seemed to be expressing the view that, on one hand, being sensitive doesn't mean providing different care to LGBT residents. On the other hand, other staff members appeared to believe that being sensitive meant treating LGBT residents differently in some ways.

Treat All Residents The Same

The idea of caring for LGBT residents the same way they care for non-LGBT residents was the most highly reported reaction given, whereby 9 of 22 (41%) participants directly stated something to that effect. This same response held up with specific questions about staff working with bisexual residents, or the family and friends of LGBT residents, thought not necessarily for transgender residents. Participants tended to express fear of showing "favoritism" or excluding other residents by providing special care to LGBT residents. They even went to far as to say that sensitivity to special resident populations was not an expectation, and that sensitivity was not justification for showing preferential treatment. They often came back to a perceived expectation to treat all residents equally, therefore not going out of their way for LGBT residents. Said one participant, "We give them care like everybody else when they get old and sick. I mean I don't…They're welcome, I mean I don't know I don't discriminate, I don't even look at that, you know. It's not even an issue for me" (Participant 1).

The approach they seemed to want to take was a 'one size fits all' approach. Participants reiterated that LGBT residents were just like other residents and deserved the same quality of

care. They seemed unable to come to the conclusion that, although all residents do deserve the same quality of care, the particular circumstances of LGBT residents might prevent them from obtaining such care. In fact, they even seemed to believe that some ways of being sensitive to LGBT residents' needs might be forms of special treatment or "favoritism" (Participant 13).

One concept that seemed to be a contributing factor to the desire to treat LGBT residents the same was a sort of LGBT-blindness. Many participants endorsed the belief that LGBT residents are no different from other residents, and so they should receive the same care as all other residents. Participants tended to say that nothing came to mind regarding LGBT residents in particular because "they're just a patient" (Participant 3). Several residents indicated that nothing came to mind about LGBT residents. One participant said, "I don't even think about it, unless someone goes out of their way to tell me" (Participant 1). Some participants went as far as to say that sexual orientation/gender identity was not as important as other factors, like a residents' personality or their illness (e.g., dementia).

Participants were shocked to hear that LGBT residents are sometimes mistreated or discriminated against, which seemed to be a way of distancing themselves from that behavior. They appeared uncomfortable with the idea of setting LGBT residents apart, even in discussion, because that might lead to treating them differently. Another form of distancing occurred when they referred to nursing homes being homophobic in the past, or to homophobia occurring in other smaller, religious, conservative towns. Essentially, participants seemed to say that mistreatment of LGBT residents occurs in other facilities, and in other places. Even participants who had worked with LGBT patients previously said they had not noticed LGBT patients being treated differently.

Some participants indicated that staff do tend to assume that residents are heterosexual, and ask questions that are heteronormative. Participant 7 provided some explanation for this, saying that staff use "default conversations" and have a "mainstream framework for joking," that may not fit well with LGBT residents. She attributed this to staff being busy and trying to multitask while talking with residents, making it more difficult to adapt conversations to residents' life experiences. Participant 9 made the point that because of this, staff may miss important cues that could help connect residents with their support network. She seemed to imply that if staff were not adapting their questions and interactions from a heteronormative (and cisnormative) model, they might miss crucial information that could negatively impact LGBT residents.

On this topic, participants sometimes referred to policies, rights, and laws that inform the way they behave at work and how they approach situations with residents. However, they showed some confusion or curiosity about how HIPPAA and confidentiality would apply to LGBT residents, particularly in trying to know their sexual orientation/gender identity. Some of their confusion also seemed to come from trying to balance confidentiality with protection or advocacy for LGBT residents. They referred to policies about treating all residents equally, and policies that stated that they needed to protect the privacy of residents.

Another important application of this theme was in staff interactions with the family and friends of LGBT residents. Some participants said that they would work with LGBT families the same way they would with non-LGBT families. As one participant said, "I think it would be the same as working with all families, and all families are different!" (Participant 20). This seems related to the earlier prioritization of individual differences over the impact of being a sexual or

gender minority. Participants said that the variability among LGBT families would be the same as among non-LGBT families.

Don't Treat All Residents the Same

Not all participants agreed with the approach of treating all residents the same. Instead, some participants talked about a person-centered approach that they would use to be sensitive to the individual needs of residents. Participants who endorsed this approach to sensitivity emphasized being aware of differences among residents, becoming well acquainted with residents, and acknowledging the diversity of residents in LTC facilities. Participant 9, being lesbian herself, seemed to emphasize providing special care to LGBT residents, given the challenges they face. Staff made comparisons to the special requests and needs that non-LGBT residents have, and indicated that it would be important to accommodate LGBT residents' needs in the same way. One social worker notably said this:

> A lot of times when I talk to my co-workers about it they say, well it doesn't make any difference, I wouldn't treat them any different. And I say, well, by not treating them differently you're actually being insensitive because you're not looking at their specific needs, and you're not taking into consideration those differences. (Participant 19)

Roommate Placement Issues

Participants' desire to be sensitive to LGBT residents came out particularly when talking about roommate placement. Participants primarily referenced policies around same-sex roommates being the standard, and seemed unsure how to be sensitive in placing transgender residents while not infringing existing policies. For example, one nurse reiterated that opposite-sex rooms were for married, heterosexual couples only, but did not provide further explanation or ideas for resolution of placing transgender residents.

Participants also discussed the factors that they would take into account when placing a resident with a roommate, and included things like dietary preferences, smoking status, resident

interests and hobbies, political orientation, and religious affiliation. However, only a few residents indicated that they would consider prejudiced attitudes of non-LGBT residents when placing newly admitted LGBT people. One of the social workers who facilitates admissions said, "I'm just looking at personality and interests. I wouldn't even take the sexual orientation into consideration to be honest. I would be looking at, are these two people going to get along? Do they have any kind of similar interests?" (Participant 14).

Using Inclusive Language

Another way participants said they would demonstrate sensitivity toward LGBT residents is through using inclusive language. However, staff seemed to struggle with this idea, as one person said, "I think it's just the language, and using the correct terms. And sensitivity." (Participant 13) In contrast, another person in the same focus group stated, "There's just a lot of sensitivity with this subject. It's more than just terminology." (Participant 9) Participants seemed to define inclusive language as using open-ended questions (e.g., "Who may I call to help support your needs?"), and non-heteronormative language (e.g., ""Is your partner coming in?"; Participant 13).

Meeting LGBT Residents' Needs

During data analysis, a connection became clear between the sensitive, person-centered approach endorsed by some participants and their ability to meet the needs of LGBT residents. Staff acknowledged that LGBT residents' needs are different in some ways from their non-LGBT peers, and that it is the responsibility of staff to meet those needs. One participant used an analogy to describe how she would be sensitive to LGBT residents' needs:

> Yes, and you know it's pretty much, helping us help how they would like to be treated….It's pretty much like a menu, somebody brings you a menu, okay, and either a waitress or waiter may come to you and say, 'May I recommend so and so, simply because… Why? It's either because it's on special, or because you look like someone

> who might enjoy this.' You know, and don't be offended. Does that make sense? (Participant 8)

This metaphor seemed to be this participant's way of trying to be non-judgmental or non-intrusive, but seemed to rely on staff's perception of residents and their needs, which may or may not be accurate. It also seems to include the stipulation that the resident not be offended, which may in itself be offensive to residents because it is an attempt to control their reaction. Several participants spoke of the need to consider LGBT residents' feelings and accommodate their particular needs. They expressed sadness and frustration at the thought of any resident being neglected or ignored, saying that they wanted "no one left behind" (Participant 20).

Staff Relationships with Residents

Based on what participants said about meeting the needs of LGBT residents, it became clear that an important aspect of this was their relationship with the residents. Participants pointed out that residents share intimate information with care providers at times, and said that staff and residents needed to be comfortable with one another to work effectively and provide quality care. However, participants identified cases where residents might be uncomfortable with certain staff (e.g., some residents preferring same-sex staff for bathing, etc.). They also identified circumstances where staff would need to put aside personal beliefs in order to provide care for residents, and said that residents' needs are more important than staff members' potential discomfort or their personal beliefs.

Participants identified factors related to building relationships with residents. One idea was that of first impressions, and how they can change. Participant 5 noted how a first impression of a resident, upon admission to the facility, might be negative, but can change once the resident is able to acclimate to the facility environment. One man emphasized the need to make good impressions, and build relationships on shared interests and common ground. Certain

values emerged from participants' discussions of building relationships with residents. These values included respect, acceptance, willingness to learn, and empathy for residents' experience. Participants also described their desire to help residents, not to hurt them, to affirm them, and not to offend. Some particularly described their fear of appearing patronizing to residents and possibly offending them. They expressed a desire to communicate respectfully.

Resident Sexual Identity and Sexual Expression

Participants talked generally about the phenomenon of sexual orientation, identity, and behavior in the facility, and meeting residents' sexual needs. They indicated that sexuality is a private matter, and said that they would provide privacy to LGBT residents—just as with non-LGBT residents—for sexual expression. However, some participants said it was unnecessary to discuss residents' sexuality. One social worker said that she would provide residents with sexual materials if they requested it, and would give them private time for sexual activity. Participants in all three facilities talked directly about how they would try to meet the sexual needs of LGBT residents. As one nurse said:

> I would like to just say that if they needed some private time in their room or in a room that they needed some private time for, you know provide them with, if they would want it, with a 'do not disturb' sign so that if they wanted to have special relations or whatever that they could have that privately. (Participant 5)

An important aspect of resident sexual expression that participants emphasized was whether the behavior was consensual or not, and if the people involved had the capacity to give consent. They indicated that this would be the same for heterosexual or cisgender residents.

Setting "Appropriate" Boundaries

Related to the topic of sexuality, participants brought up the topic of setting boundaries with LGBT residents. These boundaries included appropriate physical contact and defining their relationship with residents. They referenced a public fear of LGBT attraction, such as the fear

that LGB people might be attracted to heterosexual individuals. Participant 2 described the way that one lesbian woman she knew had responded to this fear when she said, "Just because I'm gay and you're a girl what makes you think that I'm gonna hit on you?" However, participants also seemed to minimize the attractions of LGB individuals, saying that "they'd probably be fine with it" if staff members set boundaries with residents if they showed sexualized or romantic behaviors toward staff or other residents. Finally, it seems that participants tried to equalize their reaction to "inappropriate" LGBT behavior by also indicating that heterosexual residents can make inappropriate comments too. They described situations where male residents making sexual comments about female staff, and it appeared that they were trying to say that this behavior was worse in many ways.

Intersection of Dementia and SOGI

Due to the fact that many LTC facilities provide some form of care for residents with dementia, the topic came up in connection with LGBT residents and their needs. Participants consistently approached this topic by emphasizing the importance of age regression delusions in dementia, whereby residents begin thinking they are living in an earlier time in their lives. Participants said that because of this, it is important to understand where a resident came from and what their previous life experience was like, because that may come up in the progression of dementia. Regarding LGBT residents, participants imagined how early experiences of abuse, trauma, or bullying could come up in a LTC facility. However, other participants seemed to say that dementia trumps any other aspects of the resident, such as SOGI.

Participants discussed ways they would work with demented residents in the context of those residents possibly being LGBT. They emphasized treating residents with respect, affirming their concerns and validating them. In connection with the idea of age regression

during dementia, participants emphasized wanting to know the past experience of the resident as an LGBT person, as well as finding ways to connect with them and obtain information about their daily functioning. For an agitated resident, possibly reliving a past trauma, they detailed interventions they would use to calm the resident.

Awareness of LGBT Residents' Challenges

Participants demonstrated awareness of the challenges and stigma that LGBT residents face. They talked about the challenges that LGBT people, particularly same-sex couples, face in trying to obtain medical care that respects their identities and relationships. Notably, they discussed the difficulty that same-sex partners can have in obtaining private health information from hospitals and other health care sites. However, one participant at Facility 2 said, "the people we've had here [at the facility] have not had that problem" (Participant 14). They also showed awareness of the impact that generational cohort issues play on both LGBT residents' willingness to be out, and non-LGBT residents' attitudes toward LGBT residents.

Mistreatment of LGBT Residents

Participants described experiences of discrimination against or mistreatment of LGBT residents. One aspect of this was mistreatment of LGBT residents by their peers. Participants said that they expected some intolerance on the part of non-LGBT residents, and indicated that they had little hope such attitudes would change. They seemed to exhibit a sense of powerlessness in the face of residents' prejudice or discriminatory behavior toward LGBT peers.

Staff acknowledged generational cohort issues that may impact non-LGBT residents' reactions to LGBT peers. They highlighted the stigma that LGBT identities carried throughout much of the 20th century, and suspected that any negative reactions to LGBT residents by their peers might come from generational attitudes. One participant took offense at stereotyping "that

generation," because she knew older people who were LGBT-affirmative. However, it was common for other participants to cite generational attitudes as a major reason to be concerned about the treatment of LGBT residents by their peers. One nurse explained how she would handle a situation where an LGBT resident was being mistreated:

> If I found somebody mistreating them, then I would go to the 'someone' and I would address it with them that that is not appropriate, and that it is not acceptable, because it's not. We live in America, we have freedoms! You know, and when any of the patients violate another patient's rights, that needs to be corrected and addressed. (Participant 5)

Another aspect of mistreatment that came up was at the staff level, regarding mistreatment of LGBT residents by staff. The concept of professionalism was particularly salient when participants talked about ways to prevent mistreatment. They described unprofessional staff behavior that they had either witnessed or heard of. This idea of professionalism included the idea that prejudice is unacceptable, and that being judgmental of residents is also unprofessional. Showing "favoritism" or "special treatment" to residents was also deemed unprofessional, leading to serious consequences such as termination if it occurred. Participants seemed to imply that professional behavior would ideally fix any problems in LTC facilities, and that it would prevent mistreatment of LGBT residents. They emphasized that the caregiver role they occupy is non-discriminatory, and therefore it was unprofessional to segregate residents, mistreat them, or show preference to them for some reason.

In talking about mistreatment of LGBT residents, participants made a connection between discriminatory behavior by residents and staff and the amount of knowledge they had about LGBT people. Staff said that a lack of knowledge could lead to insensitive care from staff, and to discrimination from residents. This connection between awareness of resident challenges and mistreatment and LGBT-specific knowledge is reflected in Figure 1.

Knowledge of SOGI in LTC Facilities

Regarding participants' knowledge of LGBT people, they displayed a range of knowledge of the diversity of LGBT experience and background, and the possible impact of individual differences on how they might approach an LGBT resident. However, when considering their broader knowledge of LGBT people, they struggled with the acronym LGBT, and showed awareness of their lack of knowledge on LGBT-specific topics.

Participants expressed a particular desire to learn about transgender people due to their lack of knowledge about this population. Regarding transgender residents, participants demonstrated an overall curiosity about the experience of transgender residents. They focused on the intriguing aspects of transgender people, such as their bodies and "sex change surgery," and made a reference to staff being shocked by a transgender person's body. However, staff also acknowledged that transgender residents have a right to privacy, and that their gender expression and transition is a sensitive topic.

Several participants highlighted the unique experiences of transgender residents, in that they described the difficulty of transitioning and the more visible nature of their difference from cisgender people as compared to differences between individuals of different sexual identities. Thus, they made the connection between the possible invisibility of sexual identity, but seemed to say that some aspects of transgender people are more easily discovered, thus making their experience more difficult. Participants expressed concern that such increased visibility might lead to increased prejudice and transphobic behavior on the part of other residents and staff. Still, some staff were concerned about the impact a transgender resident might have on other residents, including roommates.

Presence of LGBT Residents in LTC

Several participants said that they suspected that there might be LGB residents in their facility, but suggested that residents should make the first step in coming out, as staff would not ask about sexual orientation in that setting. They acknowledged that LGB residents might stay closeted due to stigma, but were unaware of barriers to knowing residents' sexual orientation. The executive director of Facility 3 described the lack of awareness of minority SOGI in LTC facilities when she said, "It doesn't pop into your head, 'LGBT community and nursing homes'" (Participant 21).

Participants in different facilities seemed to identify diverse approaches to knowing the SOGI of residents. Staff at Facility 3 did say that they had changed the paperwork to be more inclusive and allow admitted residents to self-identify their SOGI. Staff at Facility 2 were vociferous in stating that they do not consider residents' sexual orientation in the admittance or roommate placement procedures, as if that was a positive thing and evidence that they did not discriminate. The lesbian-identified occupational therapist there said that her facility uses a "don't ask, don't tell" approach to SOGI. Staff at Facility 1 tended to say that SOGI was not important, or at least less important than individual personalities.

It seemed that participants preferred to leave it up to residents to come out as LGBT. They talked about essentially tiptoeing around the issue, being sensitive, and almost waiting around for residents to self-identify. One participant spoke of it in this way:

> I mean it's not our job really to bring that out, if they don't want to come out. And so our job is just to make sure that they're comfortable and they get what they need, and be able meet their needs, and yeah it's uncharted territory. It's definitely a balancing act, because while you want to make sure that you're meeting everyone's needs. You also don't wanna, you know, shine the spotlight on that person or people, because it's uncomfortable, you know what I mean? It's a really fine line that we have to walk so that we can ensure that we're meeting their needs, but not encroaching on territory that we don't want to point out, or that they don't want to point out. (Participant 21)

At the same time, many participants said that there were residents in their facility at the time of the interview that they suspected were LGBT. When asked how they knew or suspected this, participants usually referenced clues from the resident's life before entering the facility, such as not having children or grandchildren and never marrying.

Experience with LGBT Residents

Participants' experience with LGBT people could be divided into two categories: their personal experience and their work-related experience. At a personal level, about a third of participants described relationships they have had with LGBT family members, friends, and acquaintances. Participant 1 discussed her gay brother's story extensively, and she seemed to come back to it often as evidence of her accepting attitude, her knowledge about LGBT people, and her reason for not needing further training. She said that she had been acquainted with one of her brother's friends who was apparently MTF transgender, although she misgendered the friend when she talked about her. Participants said that "now almost every family has a gay," (Participant 3), and described increased exposure to LGBT people in families. All of the relationships and experiences were described in positive terms.

At a professional level, about a third of participants also reported having experience working with LGBT residents. Participant 1 talked about working with gay patients during the AIDS crisis. Participant 7 recounted her experience with a lesbian resident she worked with in the past, and that "it was just known" that the woman was gay. Participant 8 talked about her experience with some older men coming out in late life and navigating the challenges of their marriage as they began the coming out process. Finally, Participant 15 spoke fondly of her experience working with a transwoman and making sure her medical needs were met (i.e., ensuring that she was given proper screening for prostate cancer). One staff member was

unaware of the experience she had working with LGBT residents, when stated at the beginning of a focus group that she had never worked with an LGBT resident. Fellow staff members in the same group informed her that she had, much to her surprise.

Attitude toward LGBT People

Overall, participants demonstrated their attitudes toward LGBT people by stating that they were accepting of LGBT people, that they did not discriminate, and that they did not judge LGBT individuals. They indicated that they were comfortable with LGBT people, and that this accepting attitude was congruent with their profession. In addition to their prior experience with LGBT people, participants identified some other factors that had influenced their attitudes.

A few of the participants identified themes related to religiosity, both their own and that of other staff. One woman identified herself in the group as Christian, and stated that she felt her religious identity was more inclusive, since other Christians might be more homophobic. Another woman referred to unprofessional behavior related to co-workers imposing their religious beliefs that LGBT people can be "cured" on other staff or residents. Not only did she identify this behavior as unprofessional, but she said that it should be met with consequences.

One factor in staff members' LGBT attitudes that was particularly salient at Facility 3 was the personal experience staff had with discrimination and prejudice. Several participants at that facility described how their acceptance of all people came from their own negative experiences with being treated differently due to a physical disability, religious identity, or ethnic identity. Staff in that facility were described as being diverse, and more accepting due to having personal experience as minorities. This seemed related to a belief that residents have the right to be out in the facility and to receive quality care like other residents. Some participants made one qualification to this, and said that some residents or staff may not approve of LGBT people, but

that they instead felt an "intolerance of intolerance" (Participant 5), whereby they were against mistreatment of other people even if they didn't approve of them.

Participants also described the ways that their family backgrounds had impacted their attitude toward LGBT people, either in a favorable or unfavorable way. Some participants indicated that they grew up with "strict" beliefs that were presumably anti-LGBT, but experienced a shift in those attitudes due to their life experience. Other participants cited their LGBT-affirmative families of origin for teaching them to be accepting of all people.

Staff-Identified LGBT Training Needs

During the group discussions, participants identified perceived training needs, or areas they would like LGBT-focused training to touch on. These may possibly be understood as areas where participants have less knowledge, experience, and understanding. Some participants expressed a desire to understand the experience of "gay residents." This may be related to their focus on residents' past life experience in a dementia context, but they also seemed to be interested in knowing what it was like for LGBT residents to be in a LTC facility. Other participants expressed a particular desire for education on the needs of bisexual individuals, as well as transgender residents. Staff seemed particularly interested in learning more about transgender residents, including how to use inclusive and sensitive language when talking to them and how to meet their needs. Furthermore, participants expressed a desire to understand LGBT-specific needs, such as how to individualize interventions for ADLs, how to incorporate LGBT-specific interests or activities into the program of the facility, and how to improve LGBT residents' self-esteem. They particularly noted that they would like transgender-specific information in order to better accommodate transgender residents, and identified this as a broad

staff training need. Overall, it seemed that these desires for further information and understanding were rooted in a desire to be "current" and sensitive.

Necessity of Training

Despite identifying specific training needs with regard to LGBT residents, participants demonstrated a variety of opinions on the need for training and the form that training should take. Participant 1 was the most outspoken against having LGBT-focused training at the facility, saying such things as, "I don't want training," and "I'm worried." She admitted to being worried that singling out LGBT residents as a population might increase stigma and further alienate them. However, Participant 1 also seemed to be ambivalent about training because she also said that other staff could probably benefit. Participant 3 seemed to think there was less need for training because HIPPAA "covers everybody," and therefore should protect against discrimination. Other participants expressed positive feelings about LGBT-specific training, stating that it could be educational, and that staff could benefit from such training. Participant 7 said that additional knowledge helps her better serve the residents, thus making a tie between staff knowledge and quality of care.

LGBT Training Content

In terms of the content of the training, participants indicated that they would prefer that topics be chosen by the presenter, with an emphasis on the needs and perspective of LGBT residents. Participants asked for personal experiences of LGBT individuals in LTC facilities, and said that they preferred hearing the experiences of older adults as opposed to younger LGBT people because that was more applicable to the residents they would work with. They asked for recommendations for ways to improve the care they could provide to LGBT residents. As far as the structure and process of the training, participants showed a preference for large-group

meetings as opposed to small group meetings initially, as some staff might be uncomfortable talking about this topic in a more intimate setting. They also indicated that they would like time for questions after the large training, in order to answer individual questions. They noted that some time for self-reflection would be useful.

Previous Experiences with Training

Some participants reported that they had received training in the past on LGBT-specific issues. They described their training experiences as "impactful" (Participant 21) and "eye opening" (Participant 2). Another woman said:

> I appreciated the training I had in the past because it just made me aware that maybe people who feel out of place in a facility anyway, and that that could add a whole extra layer and we need to make them feel comfortable about that, 'cause everybody feels weird moving into a different situation regardless of their orientation. (Participant 15)

The concept of LGBT-focused training seemed to remind Participant 2 of her experience in a "sensitivity training" in college that she attended, where she heard about the experiences of other LGBT students. She indicated that this was very positive, and that she learned a great deal from that experience that has carried over into her professional practice.

Impact of training

Because of the connection participants made between knowledge and their ability to provide competent care, the primary impact of LGBT-focused training was seen as benefiting staff and allowing them to better serve residents. One woman spoke to the global benefit of training, and seemed to say that it would help staff better serve not only LGBT residents, but all residents in the facility. She said:

> I would hope that any ongoing education we have on this matter would help us with this matter, and that matter, and, you know. I just keep seeing how it can only benefit all of us in all aspects of departments and work and contact and conversation, I mean it's a win-win situation. Because I believe it would make everyone more mindful of how we treat everyone in any situation. (Participant 20)

DISCUSSION

The present study sought to explore the cultural competency of LTC staff with LGBT residents in their facilities. Figure 1 illustrates how the core category and the main categories that were identified during data analysis are theoretically connected. These connections became apparent through memoing during analysis, as well as referring to existing conceptual frameworks about cultural competency.

The core concept that emerged from focused group discussion with LTC staff in three different facilities appears to be that LTC staff struggle with how to apply sensitivity with special resident populations, including LGBT residents. They displayed tension—both interpersonal and intrapersonal—over the ways they felt they should be sensitive to LGBT residents, while also avoiding "favoritism" or "special treatment," which were deemed unprofessional. This core concept seemed to manifest primarily in two main categories, which represented antithetical approaches to sensitivity. Some participants seemed to apply sensitivity by treating all residents the same, and others acknowledged that this approach was actually insensitive to LGBT residents. At times, even the same staff member would take the "one size fits all" approach in one context, but then talk about sensitively modifying her or his behavior in other contexts. These patterns of responding seemed to point to a "colorblind" attitude that de-emphasizes differences in a way that seems accepting. It seemed that this "hands off" approach to residents' sexual identity left staff unsure of how to approach these issues when they did come up, and contributed to the invisibility of LGBT residents in LTC facilities.

It is evident by looking at Figure 1 that although the core category seemed primarily based on the main categories of "treating LGBT residents the same" and "not treating them the

same", the preponderance of data centered around the idea of not treating LGBT residents the same. This makes sense, as the general concept of cultural competency refers to attitudes and behaviors that can accommodate differences and be adaptable to a particular population (Betancourt et al., 2002; Turner et al, 2006).

LTC staff awareness of the needs and challenges of LGBT LTC residents also seemed connected to their desire to be sensitive in caring for them. This became most obvious when participants who were aware of the challenges faced by LGBT residents in LTC also demonstrated that they needed to be more sensitive and proactive in addressing those residents' needs. For participants who were not aware of those challenges, it seemed to follow that they were unable to identify ways they could be sensitive in ways that specifically addressed LGBT residents' concerns. For example, when discussing roommate placement of LGBT residents, participants seemed to operate from a strict, binary understanding of gender that did not make room for non-heterosexual relationships and non-cisgender bodies. Similarly, participants tried to approach "inappropriate" resident behavior with sensitivity, stating that they would address problematic sexual behaviors of LGBT and non-LGBT residents in the same way. However, "inappropriate" heterosexual behavior occurs within a heteronormative environment, whereas LGBT people's behavior, appropriate or not, falls outside of the heterosexual norm and therefore may be more likely to be perceived as "inappropriate." These are only a few examples of ways that heterosexist and cisnormative beliefs can manifest in the attitudes and behaviors of LTC staff.

One particularly insightful aspect of the results is the consideration participants gave to intersecting LGBT identities with a diagnosis of dementia. Given that many LTC facilities provide services to residents who are affected by dementia and other cognitive impairments, it

appears notable that participants themselves brought up ways that LGBT residents might experience past trauma and victimization in the form of age regression delusions. Indeed, a recent call for increased cultural competence with LGBT older adults affected by dementia has emphasized the need for creating LGBT-affirmative environments, providing specialized support to LGBT caregivers, and increasing professionals' knowledge of LGBT persons' experiences (McGovern, 2014).

During the memoing process of analysis, staff sensitivity to minority SOGI appeared to be impacted by participants' knowledge, or lack of knowledge, of LGBT people in their facility, which in turn seemed connected to their level of experience with LGBT people. When they were asked about their LGBT-specific knowledge, participants often referred to LGBT people they had known in the past. At other times, the connection between sensitivity and knowledge seemed contradictory, whereby participants demonstrated less sensitivity, in part because they felt they knew more about LGBT people based on past experience. This is concerning, as such individuals are poised to be particularly insightful and experienced in caring for LGBT residents.

Similarly, participants' attitudes toward LGBT people seemed to be rooted in their experience with LGBT people. The LTC staff members in this study endorsed neutral to favorable attitudes toward sexual and gender minorities, and this was reflected in their descriptions of neutral to favorable experiences with LGBT people (e.g., co-workers, friends, family members). The fact that no unfavorable attitudes or experiences emerged may point to some level of social desirability in participants' responses, since they may have been uncomfortable talking about such feelings with their colleagues or with the researcher present. Of course, it is also possible that this accurately reflects their actual experiences and attitudes.

Finally, the LGBT-specific knowledge of LTC staff, or lack thereof, appeared related to their current training needs. Of prime importance was learning how to apply sensitivity to working with LGBT residents. This appears to explain both what staff members themselves identified as training needs, as well as what the researcher observed in the sensitivity of staff to the topic of LGBT LTC residents. It seemed that LTC staff members in this study particularly desired personal stories of LGBT residents, as well as information on how to intervene competently with them. The effect of previous training on the few participants who had received it was evident, which speaks to the efficacy of LGBT cultural competency training on changing individual knowledge, skills, and attitudes (Gendron et al., 2013; Leyva et al., 2014; Porter & Krinsky, 2014)

It appears significant that when LTC staff rated themselves on a 5-point Likert scale on their ability to work with LGBT residents, almost all of them said that they were "completely able" to work with that population. However, on average, participants reported having only "some knowledge" of LGBT people, and a "neutral" attitude toward LGBT people. From the perspective of the researcher, it became clear that many participants were unaware of the existence of LGBT residents, unsure of how to ask about residents' SOGI, and unknowledgeable about many possible needs or concerns that LGBT residents might have. Again, these are areas that LGBT cultural competency training should address with LTC staff.

An Emerging Theory for LGBT Cultural Competency in LTC Settings

At this time, it may be useful to return to the LGBT Cultural Competency Framework for Public Health Practitioners to compare it with the grounded theory for LTC staff that was developed in this study (Turner et al., 2006). The framework proposed by Turner et al. (2006) reformulates staff and providers' knowledge, attitudes, and skills into progressive stages of

awareness, sensitivity, competency, and mastery. The connections between sensitivity, awareness, and competency were manifest in different, sometimes non-linear ways with the sample of LTC staff used in this project.

Using Figure 1 as a reference, it appears that the core concept in the LTC context is sensitivity, which may be applied in different ways depending on if staff feel they should treat all residents the same or not. For those participants who talked about being sensitive to LGBT residents needs, there was an apparent connection to their ability to meet LGBT residents' needs (competency), as well as their awareness of LGBT residents and their challenges. Participants' awareness seemed to be derived from their knowledge about LGBT people, which was in turn drawn from their personal experience with LGBT people. Inadequacy of staff knowledge about LGBT residents seemed to be strongly connected to their identified training needs, as those were the areas they felt they wanted to learn about. Finally, the attitudes of LTC staff seem to stem in large part from their previous experiences with LGBT people. Although the main categories that emerged from the data reflected areas related to knowledge, skills, ability, sensitivity, competency, and awareness, it seems that they applied in different ways than was suggested in the linear model suggested by Turner et al. (2006).

The theory presented in this study, which was derived from focus group discussions with LTC staff, responds to the admonition by Turner et al. (2006) to see how models of cultural competency might be adapted to specific public health disciplines. Throughout the process of data analysis and theoretical integration, the researcher kept in mind existing models about the constructs of knowledge, skills, attitudes, and cultural competence (Fredriksen-Goldsen et al., 2014; Van Den Bergh & Crisp, 2014). He balanced that broad knowledge with constantly

referring to categories and connections between to categories to ensure that the resultant theory was not only based in existing research-based knowledge, but in the data obtained in this study.

Moving Forward: LGBT-Specific Training in Long-Term Care

The findings of this study can be useful in identifying and addressing the current training needs of LTC staff with respect to LGBT cultural competency. The resulting theory identified in this project points to education and increase of knowledge being key parts of addressing the core issue of sensitivity to minority SOGI in LTC, since knowledge is the link to other areas of competency including awareness of LGBT residents, meeting their needs, and not treating all residents "the same" (see Figure 1). Participants themselves identified areas in which they would like further training, notably in learning more about the particular challenges and experiences of LGBT older adults. They especially expressed a sincere desire to learn how to accommodate the needs of transgender residents. However, the core category identified in this study reflects perhaps the greatest training need: helping staff work through their ambivalence about providing sensitive care to subpopulations of residents who face stigma and oppression. Even well-intentioned staff seemed to say that treatment as usual was sufficient, and that they did not need to provide special treatment to LGBT residents for fear that they would be singled out, embarrassed, and discriminated against.

However, it is apparent from the existing literature that this approach only reinforces heteronormative and cisnormative imperatives and procedures in LTC facilities, thereby furthering the oppression of LGBT residents (Fredriksen-Goldsen et al., 2014). An alternative approach, based on the grounded theory identified in this study, may be to provide LTC staff with knowledge in order to be more aware of LGBT residents in their facility. Participants seemed to want to defer to residents to come out if they choose, instead of creating open

discussions of residents' sexuality, sexual identity, and gender expression among staff. Overall, it seems important to inform staff that this "treat everyone the same" approach does not adequately serve the needs of residents, or provide staff with sufficient information to do their job more effectively.

Recent publications have outlined core areas of cultural competence with LGBT older adults, and may provide further information on ways that training could increase the cultural competency of LTC staff with their residents (Fredriksen-Goldsen et al., 2014; Van Den Bergh & Crisp, 2014). One area in particular that may enhance LTC staff knowledge would be to provide them with information on ways that LGBT identities impact the life course of the people that enter their facilities. Too often, participants seemed to want to focus on individual differences and personalities, thereby negating the impact that lived experiences of stigma, victimization, and discrimination might differentially impact LGBT residents. In the same way, they might be unaware of the resiliency that older LGBT adults often develop in response to their minority SOGI (Hash & Rogers, 2013; Orel, 2004).

Another area of training that would benefit LTC staff would be focused on working with LGBT friends and family, given that they face unique barriers at social, legal, and institutional levels (Hernandez & Fultz, 2006; Shankle et al., 2003). Although some participants were aware of the challenges faced by LGBT people and their families, results of this study point to the need to educate LTC staff on the relevant differences between the experiences of heterosexual couples and same-sex couples, and how to work with them in a culturally sensitive manner. One example of this might be helping staff be more aware of LGBT-oriented resources for caregivers, such as the LGBT Caregiver Concerns brochure published by the Alzheimer's Association (Alzheimer's Association, 2012). Indeed, it appears that providing LTC staff with information

on ways to integrate and adapt their practice to LGBT residents with particular conditions, such as dementia, would be beneficial in addition to general training on LGBT older adults.

Study Strengths

One strong aspect of the present study is the diversity of the sample. A variance in participants' age, race, ethnicity, staff position, LTC experience, and time worked in their present facilities was obtained. Although the goal of sampling in qualitative studies is not to be representative, nonetheless having a wide variety of people represented in the sample increases the transferability of the results, and provides a better view into ways that all LTC staff assess their competency with LGBT residents. On a related note, the researcher was pleased to be able to speak with participants from multiple facilities, each of which had different orientations to training and prior experiences with LGBT-focused training. Staff in Facilities 1 and 2 had not had previous training on LGBT-relevant issues, whereas the staff in Facility 3 had mostly received such training. Even so, there was at least one participant in each setting who had received some level of training on the topic.

Another aspect of the study that significantly adds to the current understanding of LTC staff cultural competency is the focus on both sexual and gender minorities. It can be difficult to adequately address topics related to both LGB people and transgender individuals, and research on LGBT aging tends to focus on gay and lesbian people, while only lightly addressing bisexual and transgender people, if at all (Persson, 2009; Witten, 2012). For these reasons, the researcher expressly asked participants about their knowledge, skills, and ability related to bisexual and transgender LTC residents. Changes to the questioning route reflect this intention, as follow-up questions were added to help explore these areas (compare Appendices B and C). This appeared to be fruitful, as participants identified a strong interest in learning more about how to care for

transgender LTC residents. Although participants seemed to not know what to say about bisexual residents, this information in itself is useful, as it points to the enhanced invisibility of bisexual people in LTC settings and the particular need for training about working with that population (Rodriguez Rust, 2012).

The data collection method used in this study also appeared to be appropriate for answering the research questions, and elicited adequate information on the research topic. The use of focus groups seemed to bring out a richness in the data that would not have existed in individual interviews, because the interactions between participants fueled the development of additional themes and a greater insight into the process of struggling with the core category. For example, the high level of tension among participants in the third focus group pointed to the challenging aspects of being sensitive to LGBT residents' needs in a clearer way than might have been manifest in speaking with individuals. Participants reprimanded one another, coached one another, and taught one another based on their experiences, and it became apparent that this was a significant issue with which LTC staff continue to struggle.

Study Limitations

Although both purposive and theoretical sampling approaches were used in this study, the sample was still a volunteer sample, which may have led to some sampling biases. Participants notably endorsed neutral or favorable attitudes toward LGBT people, but spoke of other co-workers who had more unfavorable opinions of that population. Even when the researcher made attempts to ask those participants to participate, they did not join the discussions. Therefore, the data in this study may represent only staff with neutral-to-favorable attitudes toward LGBT people, and may therefore have skewed the results in that direction.

Another potential limitation is the possible inhibition staff may have experienced by talking about a sensitive topic with their co-workers. It is likely that social desirability bias played a part in what participants said during the focus groups, which contained not only peers, but also superiors and important people in their work life. It may be that staff were reluctant to share their actual opinions in that context, for fear of retribution or a negative impact on how others perceived them. Although the researcher did his best to acknowledge this and provide participants with opportunities to speak individually or to respond individually to transcribed group discussions, participants did not take those opportunities.

When trying to contact LTC facilities to invite their staff to participate, the researcher experienced a great deal of difficulty communicating and receiving responses from facilities. Although it is impossible to know the exact reasons, it can be imagined that openness to the topic, time and availability of staff, and understanding of the project were potential factors in the lack of response from the other facilities. This may typify barriers to studies of this type, which constitutes a limitation to sampling LTC facilities in a given area.

Finally, it should be noted that although studies of this type are not intended to be generalized to the general population, they are intended to be transferable to similar people in similar contexts. Even so, participants in this study originate from one region of the United States, in mostly suburban or urban areas. It may be that a similar project conducted in other regions of the country or world would produce different results.

Future Directions

This exploration of LTC staff cultural competency with LGBT residents holds several implications for further research in this area. Since research on this area is still in the exploratory phase, it seemed appropriate to use qualitative research methods to obtain a rich understanding of

this topic in the LTC context. However, quantitative studies or qualitative studies with a different focus could also produce important information in this area.

Since the participants in this study came from diverse training backgrounds and disciplines, it may be useful to employ a similar design with homogeneous groups of LTC staff, in order to better understand differences among social workers, administrative staff, nursing, medical providers, mental health professionals, and so on. This was not the primary goal of the present study, but such an approach may offer further information on the topic of LGBT cultural competency in LTC.

This theory is inherently bounded by the time and context in which it was obtained. One could imagine that, after significant cultural shifts in attitudes in the United States and increasing visibility of LGBT people in LTC facilities, the tensions that define the core category would diminish. Therefore, it will be necessary to continually re-assess how this model applies to LTC staff, and modify as necessary in the coming decades.

This study was decidedly not interventional in nature, as its purpose was to describe and explain the phenomenon of LGBT cultural competency in LTC facilities. However, it is clear from the results that interventional research would be useful in piloting forms of LGBT training among LTC staff members. Such studies could take the identified training needs and form them into a training program for LTC staff, and document the impact of such training, using qualitative and quantitative methods. Recent quasi-experimental and qualitative studies on the effectiveness of LGBT aging training have shown promising results in increasing the cultural competency of aging services providers, and the results of this study may provide further information about information to include in such trainings (Gendron et al, 2013; Leyva, Breshears, & Ringstad, 2014; Porter & Krinsky, 2014). Again, the areas of cultural competence

with older LGBT adults provided by Fredriksen-Goldsen et al. (2014) and Van Den Bergh and Crisp (2014) may provide a useful framework for such trainings, as the areas defined by those authors overlap with the stated training needs of participants in this study.

Conclusion

The findings of the present study are, at the same time, alarming and encouraging. The hesitancy of LTC staff to reach out to LGBT residents and deliberately create an LGBT-affirmative environment is concerning, as is the "one size fits all" approach they tend to endorse when talking about working with LGBT residents. Given the power differences between LTC staff and residents, it behooves the staff members and facility directors themselves to make it known that they largely accept and affirm LGBT people in their facility, and adapt their practice to meet the unique needs of LGBT residents and their families. Additional training should assist LTC staff in knowing exactly how to do this in clear behavioral steps, both at personal and institutional levels.

Even so, the results of this study are encouraging as they show that some LTC staff are aware of the challenges that LGBT residents face, and that they can advocate for fair treatment and compassionate care of those residents. It seemed that these staff members might not always openly voice their opinions and desires to be sensitive to all special populations of LTC residents. Therefore, it may be helpful to assist facilities in developing a work culture of open dialogue that allows for sharing ideas and opinions on how to care for LGBT people.

Overall, this study presents in-roads into changing the evident heteronormative and cisnormative attitudes and practices in LTC facilities. By building LTC staff members' awareness of LGBT people and their challenges, and giving them the words and the permission to directly address the particular needs of LGBT people in their facilities, it is hoped that LTC

staff will become more effective in practicing culturally competent care with not only LGBT residents, but with all LTC residents.

Table 1

Demographic Information of LTC Staff Members

Participant	Sex[a]	Age	Race/ Ethnicity[b]	Religious Affiliation	Employment Position	Education	Time in LTC[c]	Time in Facility[c]
1	F	66	WNH	Catholic	Registered Nurse	Some College	15	8
2	F	40	WNH	Buddhist	Social Worker	College Degree	18	1.5
3	M	52	AFA	None	Janitor	HS/GED	16	3
4	M	58	HL	Lutheran	Payroll Manager	Some College	10 mo.	10 mo.
5	F	58	WNH	Christian	Nurse	Some College	10	6
6	F	44	WNH	Protestant	Nurse	Some College	8	8
7	F	36	WNH	None	Therapy Program Manager	College Degree	13	1
8	F	58	HL	None	CNA/RNA	HS/GED	26	2
9	F	48	WNH	None	Occupational Therapist	Master's Degree	13	7.5
10	F	42	NA	None	CNA	Some College	20	1
11	F	44	WNH	Christian	Transport/CNA	Some College	28	4
12	F	23	ASA/MR	Catholic	Recreation Director	Some College	3	3
13	F	44	WNH	None	Director of Marketing	Some College	14	4
14	F	46	WNH	Christian	Social Worker	Graduate Degree	15	20 mo.
15	F	52	WNH	Catholic	Clinical Dietitian	Master's Degree	13	2
16	F	35	WNH	None	Medical Records/Nurse	Some College	15	5
17	F	22	NA	Christian	Nurse Aide/Admin Assistant	Some College	7	1
18	M	40	WNH	Pentecostal	IT Services	College Degree	20	6.5
19	F	23	HL	None	Social Worker	Graduate Degree	2	5 mo.
20	F	72	HL	Protestant	Activity Department	Some College	9	9
21	F	44	WNH	Jewish	Executive Director	Graduate Degree	15	15
22	F	58	WNH	none	Executive Director of Finance/Business	Some College	3	3

Note. [a]For sex, M = male, F = female. [b]For ethnicity, EA = European American, HL = Hispanic/Mexican American, AFA = African American, ASA = Asian American, NA = Native American, MR = Multi-Racial. [C]For Time in LTC and Time in Facility is measured in years unless otherwise indicated.

Table 2

Staff Self-Assessment of Knowledge, Skills, and Attitude With Respect to LGBT People [a]

Variable	*M*	*SD*	Qualitative Descriptor
LGBT Knowledge	2.36	1.00	Some Knowledge
Feelings Toward LGBT People	2.86	0.89	Neutral
Ability to Work with LGBT Residents	3.81	0.59	Somewhat Able

Note. $n = 22$

a. Responses were based on a 5-point Likert scale, with 0 signifying the lowest and 4 signifying the highest level in each domain.

Table 3

Main Categories and Subcategories for LTC Staff Sensitivity to Minority SOGI of Residents

1. Treat All Residents the Same
    a. LGBT-Blindness
    b. Distancing and Denial
    c. Heteronormative Staff Behavior
    d. Policies and Legal Issues
2. Don't Treat All Residents the Same
    a. Roommate Placement Issues
    b. Using Inclusive Language
3. Meeting LGBT Residents' Needs
    a. Staff relationships with residents
    b. Resident sexual identity and sexual expression
    c. Setting "appropriate" boundaries
    d. Intersection of SOGI and Dementia
4. Awareness of LGBT Residents' Challenges
    a. Mistreatment of LGBT Residents
    b. Age/Generational Cohort Issues for non-LGBT Residents
    c. Prejudice Difficult to Change
    d. Heterosexist and Homophobic Behavior
5. Knowledge of SOGI in LTC Facilities
    a. Presence of LGBT Residents in LTC
6. Experience with LGBT Residents
    a. Experience with LGBT People in Personal Life
    b. Work-Related Experience with LGBT People
7. Attitude Toward LGBT People
    a. Family Background
    b. Religious Orientation
    c. Staff Experience of Prejudice
8. Staff-Identified LGBT Training Needs
    a. Necessity of Training
    b. Content of Training
    c. Previous Experience with LGBT Training
    d. Impact of Training

Note. A majority ($n > 11$) of participants was represented in all categories.

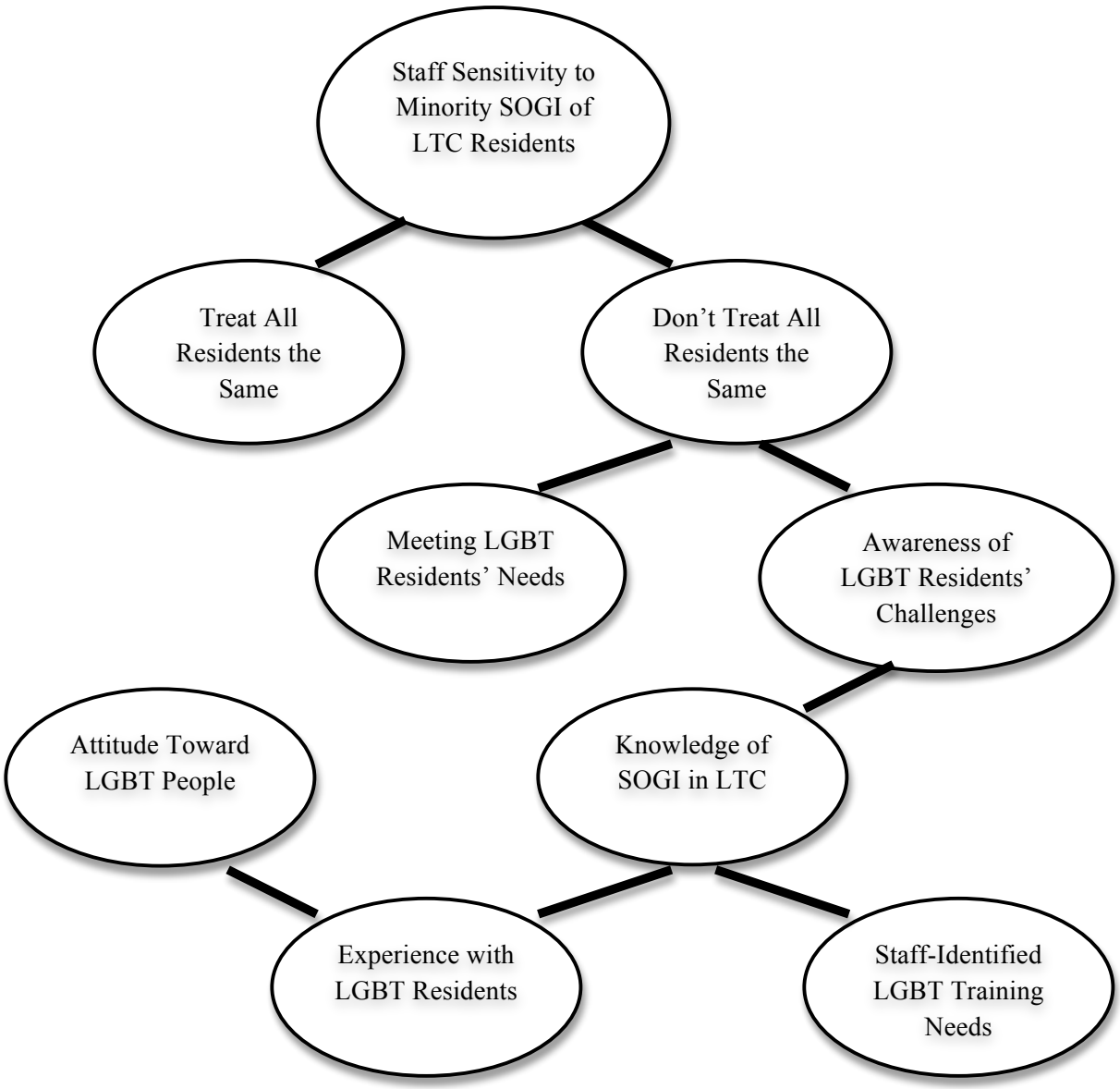

Figure 1. A Framework of LTC Staff Sensitivity to Minority SOGI of Residents

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APPENDIX A

Demographic Information Sheet

Please take a moment to answer the following questions about yourself. Information from these questions is intended to help the researcher know your background and basic demographic information. All the information you provide will be kept confidential, and there is no need to identify yourself on this form. We remind you that participation is completely voluntary. Thank you for your willingness to participate!

Please circle one answer for each question:

1. **Gender**: male female transgender (MTF / FTM)
2. **Sexual orientation**: heterosexual
   gay
   lesbian
   bisexual
   other: _____
3. **Age**: _____
4. **Ethnic heritage**: African American
   Hispanic/Mexican American
   Asian American
   Native American
   Multi-Racial
   White/Non-Hispanic/European American
   Other _____

5. **Religious affiliation**: _____

6. **Current employment (position): _____**

7. **Highest level of education**:

   _____ Some High School

   _____ High School Diploma (up to Grade 12) or GED

   _____ Trades School or Community College (Associate's Degree)

   _____ Some College (less than 4 years or no degree)

   _____ College Degree (Bachelor's or 4-year degree)

   _____ Graduate/Professional Degree (Master's Degree, Ph. D., M. D., Psy. D., or other degree requiring graduate education)

8. **How long have you worked in long-term care? _____**

9. **How long have you worked in your current facility? _____**

10. **How much do you know about LGBT people in general? (circle one)**

I know nothing at all	I know very little	I have some knowledge	I have adequate knowledge	I'm an expert

11. **How would you describe your feelings toward LGBT people? (circle one)**

Highly unfavorable	Unfavorable	Neutral	Favorable	Highly favorable

12. **To what extent do you rate your ability to work with LGBT residents in your facility? (circle one)**

Completely unable	Somewhat unable	Unsure	Somewhat able	Completely able

APPENDIX B

Questioning Route for Focus Groups

Today I'm going to be asking you questions about various aspects of your work here in this LTC facility.

1. Tell us about yourself, and what your role is here in the facility.
2. What is the first thing that comes to mind when you think about working with residents who are lesbian, gay, bisexual, or transgender?
3. How do you feel about LGBT people in long-term care?
4. What do you know about LGBT people in long-term care?
5. What special considerations would you make in working with someone who was LGBT?
6. What would be difficult about providing services to LGBT residents?
7. What would be rewarding about providing services to LGBT residents?
8. If you received further training on working with LGBT residents, what areas would you want the training to focus on?
9. If you received further training on working with LGBT residents, what would be the most useful method for giving the training?
10. What do you think your co-workers would benefit from learning about how to care for LGBT residents?
11. Is there anything that I missed? Anything you wanted to say but did not yet have a chance to say?

APPENDIX C

Revised Questioning Route for Focus Groups

Today I'm going to be asking you questions about various aspects of your work here in this LTC facility.

1. Tell us about yourself and say what your role is here in the facility.
2. What is the first thing that comes to mind when you think about working with residents who are lesbian, gay, bisexual, or transgender?
    a. What comes to mind when you think about bisexual residents?
    b. What comes to mind when you think about transgender residents?
3. In your opinion, how are LGBT residents the same as other residents? In what ways are they different?
4. What personal experience do you have with LGBT people?
    a. How does your experience with LGBT people influence how you might work with them in this facility?
    b. How have you / might you become aware of LGBT residents you work with?
5. How do you feel about LGBT people in long-term care?
    a. How do you feel about transgender people in long-term care?
    b. How do you feel about bisexual people in long-term care?
6. What do you know about LGBT people in long-term care?
    a. What do you know about bisexual people in long-term care?
    b. What do you know about transgender people in long-term care?
7. What special considerations would you make in working with a resident who was LGB?
    a. How would you address bathing, room placement, etc. with LGBT residents?

b. What special considerations (bathing, placement, etc.) would you make working with a transgender resident?
c. How do residents' psychiatric/medical presentations influence how you might approach an LGBT resident?
    i. What priority do you give medical/psychiatric concerns versus aspects of residents that relate to their identity?
d. How would you work with family/friends of an LGBT resident?

8. What would be difficult about providing services to LGB residents?
9. What would be difficult about providing services to transgender residents?
10. What would be rewarding about providing services to LGB residents?
11. What would be rewarding about providing services to transgender residents?
12. If you received further training on working with LGBT residents, what areas would you want the training to focus on?
13. If you received further training on working with LGBT residents, what would be the most useful method for giving the training?
    a. What format would work best?
14. What do you think your co-workers would benefit from learning about how to care for LGBT residents?
15. Is there anything that I missed? Anything you wanted to say but did not yet have a chance to say?