

**Transforming Mental Health Services for Older People:  
Lesbian, Gay, Bisexual and Transgender (LGBT)  
Challenges and Opportunities**

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**Article Synopsis**

Service providers often think about “minority” group members as challenges: How do we adapt our existing protocols and programs to meet the needs of these people over here who are *different* from our usual clients? Unfortunately, we frequently attempt to answer this question by trying to gain “cultural competency,” a code phrase that all too often stands for this directive: “substitute this (just slightly more nuanced) set of stereotypes for the set you have been using.” This approach neither serves individual clients - who can never be summed up by a single attribute, whether that be their race, age, gender, sexual orientation, or psychiatric diagnosis - nor makes full use of the opportunities for systems improvement that diversity creates.

This article offers alternatives to this standard (and inadequate) response to diversity by exploring four ways in which engaging aging diversity can actually improve both our services and the broader community.

I. “Cultural competency” as it relates to any individual client requires far more than knowing what life is like for “her group.” Using older lesbians, gay men, bisexual people and transgender people (LGBTs) as examples, the first part of this article presents a multi-faceted schema for thinking through relevant aspects of *all* clients’ backgrounds.

II. Keeping in mind the concept of “universal design,” the aging network could improve services to *all* of its constituents by meeting the needs of any given minority group. This

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section explores what all elders might gain if the aging network redesigned itself to meet the needs of LGBT elders.

III. Mental health services are just a small part of what elders need, but by focusing on the broader question of what mental health means to elders - and particularly “minority” elders - the aging network could make invaluable contributions to people of all ages.

IV. To give readers a starting place for change, the article ends with a list of highly useable “take home messages.”

## I. Components of (LGBT) Cultural Competency: Who, What, Where, When, How, and Why

As previously noted, all too often “cultural competency” is a code phrase for this directive: “substitute this (just slightly more nuanced) set of stereotypes for the set you have been using.”

When it comes to lesbian, gay male, bisexual, and transgender (LGBT) elders, this version of cultural competency treats these four very different and diverse populations as one, and contrasts them to a “normal heterosexual” elder. From this perspective, the major differences can be summed up in a sentence or two: Up until recently, no gay male or lesbian couples could have the more than 1,000 benefits that go with heterosexual marriage; homosexuality was widely seen as a crime and/or a mental illness during most of LGBT elders’ lives; because of bad experiences with punitive social and governmental institutions, LGBT elders are probably less likely to accept public services such as home care than are heterosexuals. However, this list of differences is just a slightly more sophisticated type of stereotyping than what we currently have, which is a presumption that all of our elders are heterosexual. Such broad strokes tell us little about any given lesbian, gay male, bisexual, and/or transgender elder.

At the same time, it doesn’t seem humanly possible to approach each person as a blank slate. In the absence of actual knowledge about an individual, we may well make up “data” without even being aware of it, then choose our initial approach and conversation on the bases of these “givens.” An alternative is to approach each individual in a more systematic and sophisticated way. Instead of summing up an individual with one identity label and calling up a stereotype about *that* group, think about each new individual as a multi-dimensional collection of experiences and influences. These factors can be thought through systematically by recalling the five “W’s” (plus “how”) we were all taught in English class: Who, What, Where, When, How, and Why.



Who did this person grow up around? (culture)

A 61-year-old Amish man who is sexually attracted to other men is likely to view himself quite differently than is the 61-year-old gay man who was born to Broadway stars.

What did this person grow up as? (“us” and “them” binaries)

Human cultures are rife with either/or binaries: male or female, one race or another, “professional” or “blue collar.” These dichotomies can usually be boiled down to one or two binaries: Are you like me or not? And, are (or were) you stigmatized, or viewed as “normal”?

The habitual assignment of someone into “us” or “them” not only happens very quickly, but also carries with it enormous additional assumptions. If I think you are “like me” and are a part of my group - however I define that group - I am more likely to be comfortable around you, to believe you understand “where I’m coming from,” and to trust you. Although this can set us up for a positive interaction, it can also lay the groundwork for antagonism. It is common, for instance, to associate certain races, sexual orientations, and the like with certain politics, and many interpersonal and group conflicts have ensued when someone made it clear that despite looking like one of us, they didn’t hold the same political beliefs. This is where we get the cookie and other food analogies: one color on the outside, another on the inside.

On the other hand, if I immediately class you as “not like me,” a different set of assumptions goes into effect. I will presume you were at least brought up to think differently than I do, and you might even be intrinsically different (“men are from Mars, women are from Venus”). That means I will likely expect communication to be harder, I am more wary about you misunderstanding or hurting me, and I may even see you as my enemy. Common phrases that reflect the potency of common us/them divisions are “the war between the sexes” and “the color line.” Note that one does not necessarily have to believe one group is better than the other to experience the us/them division; I do not need to believe that being a geologist is better than being a gynecologist to talk to you differently if you are one and I am the other.

In contrast, the “stigmatized” versus “normal” dichotomy does include a judgment that one is better than the other. An example of this in the U.S. would be a white female elder objecting to having an African-American health aide sent to her home. Interestingly, many groups who are stigmatized cope with this put-down by reversing the hierarchy and seeing themselves as better than the “normal” group: imagine what that “dissed” Black woman might be saying about



the older white woman who is no longer capable of bathing herself. Whichever part one plays, if two people are from opposite sides of the stigmatized/”normal” dichotomy, they will generally, at least initially, find it hard to trust one another.

The “stigmatized” versus “normal” dichotomy is often harder to recognize in everyday situations than the “us” or “them” dichotomy, because many stigmatized characteristics - like being lesbian, gay, bisexual, or even transgender - are not visible. However, clients know they belong to a stigmatized population, even if *you* assume they are just like you. This is where a lot of aging professionals get tripped up: we don’t understand why this person who otherwise seems so understandable to us is having a reaction we don’t understand. If we would immediately make a doctor appointment when our shoulder wound became abscessed, it may never occur to us that this similarly-situated person is resisting because he is a female-to-male (FTM) transgender person and does not want to risk being told to take off his clothes.

### Where did this person grow up? (geography)

A Thai woman in her 70s who is third-generation American is likely to be quite different from the 74-year-old Thai woman who left her farm in Thailand five years ago to come to the U.S. to provide childcare for her grandchildren. Both may have very different reactions to a child transitioning from male-to-female (MTF); in Thailand, a significant slice of the economy is based on providing gender realignment surgery for American and European MTFs, and the relationships that develop between Thai nurses and their patients sometimes include back-and-forth transatlantic visits spanning years. So the Thai native may actually be more accepting than her more Americanized peer.

### When did this person grow up? (age cohort)

Major cultural events shape individuals’ personalities. Americans who grew up during the Great Depression often are far more careful about saving and spending their money than are baby boomers, who grew up in a time where things just seemed to keep getting bigger and better. Those who have always entered school by walking through a metal detector have a very different sense of how safe they are in public places than do those of us who were taught that a desk over our heads would save us from nuclear war.

What is critical for those of us in the aging field to remember is that we are dealing with *multiple* age cohorts simultaneously. One of the remarkable things to think about with aging is that when we talk about “elders,” we are talking about people who can have 50 years’ difference in age. That used to be an entire average lifespan! You wouldn’t expect a person to be the same at age 4 as they



are at 54, and we need to be very careful not to presume that what is true of a 60-year-old bisexual man is true of a 95-year-old bisexual man. They were at the prime of their adulthood in very different environments for gay people. The 60-year-old, for instance, is far less likely to have married a woman and kept his sexuality a secret from her than the 95-year-old man was, to name but one major lifecourse difference.<sup>2</sup>

How much money and options did this person have? (class)

In a capitalist country, money buys opportunities. The 86-year-old woman who grew up the daughter of an Iowa sharecropper is likely to have led a very different life from her age peer who was born to the Iowa governor, himself the son of a railroad baron. Both may be lesbians, but one is far more likely to have had more formal education, traveled abroad, and been a professional woman than is the other.

Why have things happened, according to this person? (locus of control)

Trauma theory is beginning to explore the implications of how people think about what has happened to them. Two of the trauma field's leading theorists, Bessel A. van der Kolk and Alexander C. McFarlane (1996, p. 6), put it this way: "So, although the reality of extraordinary events is at the core of PTSD [Post-Traumatic Stress Disorder], the meaning that victims attach to these events is as fundamental as the trauma itself."<sup>3</sup> Thus, a closeted gay male elder who believes homosexuality is a blight on the family honor may have a very different response to being beaten and robbed by his grand-nephew than will the proud gay activist who believes his grand-nephew is a lazy thug. The first man is far more likely to internalize and hide the trauma's resulting hurt and shame, and the second more likely to feel anger and take actions to ensure his grand-nephew isn't able to hurt him again.<sup>4</sup> Whether someone feels he has value and power in the world or is an abomination has profound implications for that person's physical and mental health, including whether he or she will seek or accept assistance.

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<sup>2</sup> To help people grasp what current LGBT elders have lived through, the Transgender Aging Network has prepared a "Living Memory LGBT Timeline," available at [http://www.forge-forward.org/handouts/LGBT\\_elder\\_timeline.pdf](http://www.forge-forward.org/handouts/LGBT_elder_timeline.pdf)

<sup>3</sup> Van der Kolk, Bessel A. and Alexander C. McFarlane, "The Black Hole of Trauma," in *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Science*, edited by Bessel A. van der Kolk, Alexander C. McFarlane, and Lars Weisaeth (1996), p. 6.

<sup>4</sup> For more information about abuse of LGBT elders, see "Lesbian, Gay Male, Bisexual and Transgendered Elders: Elder Abuse and Neglect Issues," by Loree Cook-Daniels (2002), available at <http://www.forge-forward.org/handouts/tgelderabuse-neglect.html>



## II. “Universal Design” of the Aging Network, from an LGBT Perspective

Oftentimes when advocates try to talk to service providers about LGBT elders, those service providers say they don’t serve any. This is probably not true. In the 2000 U.S. Census, there were 600,000 self-reported lesbian and/or gay male couples in 99.3% of all American counties. One in ten of those couples included at least one person 65 or older. Since census forms had no place for any transgender designation or for single, separated, or widowed lesbians, gay men, and bisexuals to declare those identities, we can very safely assume there are many more than 1.2 million LGBTs in the U.S. So chances are good that if you are serving elders, you’re serving LGBT elders, as well.<sup>5</sup>

Even if you’re not sure you actually serve any LGBT elders, designing systems to meet the needs of LGBT elders could benefit *all* of your clients. The Transgender Aging Network and its host organization, FORGE, describe this phenomena as “universal design,” a term borrowed from the disability rights movement. Universal design in this context means that if you set up your system or program to accommodate the client or clients who are *most unlike your typical client*, you will automatically create a system that better meets *many people’s* needs.

A traditional “universal design” example would be a ramp up to a building entrance: such a structure is critical for someone in a wheelchair, but it is also extremely useful for people who have arthritic knees, delivery people pulling wheeled carts, and parents pushing strollers. For a transgender example, take bathrooms. If you create a bathroom that can be used by someone who does not identify as *either* male or female, you suddenly have a bathroom that can *also* be used by: fathers accompanying their young daughters; men with disabilities who are assisted by female caregivers; male staff assisting female elders with severe dementia, *and* standard-issue men and women of all ages and abilities. We now call these “family bathrooms.” Transgender people call them “life savers.”

Many of the aging network’s current assumptions and systems simply do not work for LGBT elders. Here are some of those areas, along with how addressing them might improve life for non-LGBT elders, as well.

### Legal hierarchies and rights based on relationship status

Under current law, people who are related by blood or marriage are automatically given many rights not available to people who are not related by blood or

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<sup>5</sup> One of the sources of this U.S. Census data was retrieved May 24, 2007 from Human Rights Campaign, “Commercial Closet Report: U.S. Census Offers New Same-Sex Couple Data, As Research Booms,” at <http://www.hrc.org/Template.cfm?Section=Home&CONTENTID=19717&TEMPLATE=/ContentManagement/ContentDisplay.cfm>



marriage, even if they have pledged allegiance to each other's wellbeing. This presumption is so sacrosanct that lesbian and gay couples who have created legal documents like powers of attorney and wills have had those documents ruled invalid by judges who say relationships set up by law trump individuals' actual, declared relationships and choices. If one of the goals of the aging network is to preserve and nurture the interpersonal relationships we have found are crucial to healthy aging, we need to examine whether part of our mission must be to dismantle the laws and regulations that ignore or actively undermine such relationships, or at least restructure our programs on other bases.

## Benefits based on relationship status

Similarly, when the aging network knows how critical sufficient income is thriving in old age, are we working against our own goals when we turn a blind eye to systems that financially reward some relationships but not others? Social Security survivor benefits are never available to same-sex couples, no matter how long they have been together, how they have structured their financial lives, or even whether they live in a state that has granted them a marriage license. Even tougher to address is the challenge posed by lesbian and gay activists who argue that legalized gay marriage still misses the boat, by ignoring the fact that the extended support networks and chosen families many lesbians and gay men depend upon do not fit the two-married-people model. How is the aging network going to respond to the challenges of sponsoring programs - including housing and meal programs -- that financially reward some relationships and not others, when we already know for a fact that many elders cannot depend on legal spouses or children for their financial support?

## Your rights are a threat to mine

One of the most difficult challenges currently facing the LGBT community is the public media campaign telling heterosexuals that recognizing gay couples and families threatens the rights and/or security of heterosexual couples and families. Previous opponents to other civil rights campaigns have also tried to say there are a limited number of rights, and that granting new rights to some means taking away existing rights from others (white people's "right to free association," for instance, was allegedly challenged by civil rights laws that made race-based service restrictions illegal). Nevertheless, the centrality of families and family values to American life make this new campaign particularly virulent and divisive. It may be driving wedges between LGBT elders and other minority elder groups who greatly value "traditional" families. If the aging network wants to make a safe, welcoming space for all elders, how are we going to address the fears and insecurities being created by some of those who oppose lesbian and gay marriage?



## Sex segregation

Just as we no longer have separate bathrooms and drinking fountains for particular races as a result of civil rights laws, the challenges posed by transgender people may spell the beginning of the end of separate-but-equal services and facilities based on gender distinctions. Nursing homes are already having to figure out whether to assign a male or a female roommate to the transgender elder who is both a woman and has a penis. This challenge is going to get much more intense as the decades pass and the young people who are currently refusing to identify as either female or male begin aging over the “elder” line.

### III(A). The Grand Opportunity: Changing How Everyone Thinks About Mental Health

In recent decades, our understanding of “health” and how it is achieved has radically shifted. We used to define “being healthy” as an absence of illness or injury. When we did get ill or injured, we went to a doctor to have him or her restore us to health.

In part because demographic and health shifts gave us a critical mass of aging people to learn from, we have increasingly understood more about how bodies and their environments work and interact. Consequently, we have moved from thinking that the threats to health are evil spirits, bad luck, or “germs” to an understanding that “health” is dependent upon innumerable everyday human decisions, accumulated over time. Part of what we have realized is how dependent our health is on the actions other people take: how the food we eat is grown and prepared by people we will never meet; what industries we will never hear of put into the air we breathe and the water we drink; whether or not our social and economic systems permit us to access health care; and whether pharmaceutical firm executives have decided there’s enough potential profit to develop the medications we need to treat our acute and long-term conditions. We have also increasingly recognized how much our personal, routine, moment-to-moment decisions affect our health: how much time, knowledge, and effort we put into feeding and exercising our bodies; whether we soothe ourselves with cigarettes, alcohol or drugs; even how robust our social networks are...all affect our overall health.

“Making us healthy” is no longer the job of doctors and hospitals, but instead involves the whole community through constant health education and promotion efforts by institutions such as schools, churches, workplaces, government agencies, and, of course, the media. Instead of finding health at an appointed time with a duly certified professional, we now know that a thousand everyday, personal, business, and government decisions sum up to a “health” far broader than a simple absence of injury or illness.



We may be at the very beginning of a similar transformation in our conception of “mental health.” Our conception of health changed in part because social evolutions revealed patterns that had previously been obscured. We didn’t realize how critical physical movement is to health until we evolved from a society in which most of us did physical work and walked all day into a society in which most of us sit all day in chairs and cars. Similarly, social changes are slowly bringing into focus some of the components of mental health. “Mainstreaming” children and adults with developmental disabilities, the de-institutionalization of our chronically mentally ill, and the advent of medications that have helped some psychiatrically ill individuals achieve remission of symptoms have all led to more public awareness of conditions that affect mental functioning. The advent of mass media brought with it not only widespread vicarious participation in traumatic events - the Oklahoma City bombing, 9/11, school shootings - but also “anniversary coverage” that has helped many recognize that one incident can profoundly alter life courses.

We’re also seeing a rapidly growing awareness of the long-term emotional effects of trauma, a process that began with the return of many Vietnam veterans with what we have now identified as post-traumatic stress disorder. More recently studies have been published documenting lifelong health effects from childhood abuse, and we are just beginning to glimpse the long-term aftermaths of natural disasters like Hurricane Katrina and human-made destruction in Africa and elsewhere.<sup>6</sup> Substance abuse programs are beginning to recognize and address the untreated emotional traumas that set so many on a course of self-medication.<sup>7</sup>

The past several decades’ development of programs to assist domestic violence and sexual assault victims has raised our awareness of how much everyday violence and control tactics permeate our most intimate relationships. As the “violence against women” movement continues to grow in its ability to recognize male victims and female perpetrators (an awareness that begin with the recognition that lesbian and gay male couples also experience domestic violence), we will become better positioned to understand the true scope of this problem, along with its implications and, possibly, avenues for more effective intervention and prevention.

As our understanding of all that impacts on mental health problems continues to evolve, we may well begin to see mental health emerge not only as a far more complicated and nuanced state, but as one that must be supported and nurtured throughout *all* of our

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<sup>6</sup> For information on the Adverse Childhood Experiences and their relationship to adult health, see <http://www.acestudy.org/docs/GoldintoLead.pdf> (retrieved May 24, 2007). Many examples exist of coverage of the long-term effects of natural and human-made disasters; some can be accessed in the “News Room” at the Witness Justice website, <http://www.witnessjustice.org/>

<sup>7</sup> See, for example, the Substance Abuse and Mental Health Services Administration’s National Center for Trauma-Informed Care, at <http://mentalhealth.samhsa.gov/nctic/default.asp>



social institutions and norms (not just in therapists' offices). We may come to appreciate the long-term mental health effects of everyday realities like living in dysfunctional families, being constantly steeped in a stew of actual and virtual violence, scrambling to secure and keep access to basic life sustaining resources, and living in communities liberally sprinkled with people for whom being shot at is a common occurrence. We *may* even come to recognize the long-term mental health effects of things our "minority" populations know well: what happens when our closest relationships are devalued and denied; how it feels to be told that one's group is a threat to American values and families; or what it means to be told for decades on end that you are not as good as someone else.

### III(B). The Role of the Aging Network and "Minority" Populations

Just as it did with our expanded understanding of health, the aging network could play a critical role in helping advance our society's understanding of what goes into mental health. The resources we need to understand what contributes to human resilience and what contributes to human despair and dysfunction are already within aging programs. Our challenge is to help these survivors articulate their stories, and then to help aggregate those stories into testable theories that can point the way to necessary mainstream social changes.

- Survivors of the Jewish Holocaust can shed light on what it takes to put a life back together after the genocide of your people, information we're going to need in order to help heal the survivors of Iraq, Sudan, and many other places.
- Aging immigrants from Africa and Laos who survived moving from rural, agrarian societies into very technologically advanced urban centers could help us learn how to help people psychologically adapt to major lifestyle changes, something that nearly all of us are challenged to do in a rapidly-changing world.
- Vietnam veterans - now aging into the aging network's programs -- could shed light on how to recover from having your society send you into a place where you can expect to kill and be killed, information we are going to need to successfully reintegrate our Iraq and Afghanistan veterans.
- Elders who transition from one gender to another in mid- or later-life - and particularly the family members and partners who stay with them through such a shift -- can help us understand what it takes to give up one identity in favor of another, and how family bonds can survive personal changes the rest of society



says are impossible.<sup>8</sup> We need to distill these lessons to help in a myriad of situations where people are coping with life changes they did not choose.

- Lesbian and gay older couples have much to teach us about building and maintaining strong partnerships even in the face of multiple mass media campaigns holding that such relationships are threats to other people's families and marriages and American values. These skills are needed by everyone who even occasionally finds themselves on the "wrong" side of others' strongly-held values.
- Members of the LGBT community as a whole are experts in building chosen families and support networks based on affiliation rather than blood or legal documents, information the aging network already desperately needs as we try to fill the practical, financial, and emotional support gaps left as elders live longer and have smaller, more mobile families.

What would it take for the aging network to start collecting these stories, making the connections between them, and feeding them back into the larger community?<sup>9</sup>

#### IV. Take Home Messages for the Aging Network About Minority Elders

Although this article has addressed big ideas that may take some work to implement, there are small, practical steps service professionals can take immediately to start the balls rolling. Here are several suggestions.

##### **Avoid substituting one stereotype for another**

Individuals are not just their culture, their sexual orientation, their age, their nationality, or any other single identifier; they are all of the above, and much more. Although it is very, very useful to know and be appreciative of the panoply of different ways people live their lives, ultimately you can only know what is important to a person by asking her the right questions *and listening to the answers*.

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<sup>8</sup> For a much more detailed discussion of transgender elders and SOFFAs (Significant Others, Friends, Family, and Allies), see "Transgender Elders and SOFFAs: A Primer for Service Providers and Advocates," by Loree Cook-Daniels (2002), available at <http://www.forge-forward.org/handouts/TransEldersSOFFAs-web.pdf>

<sup>9</sup> For another discussion of the lessons "minority" groups can teach the broader community, see "The Future of Aging: Re-Defining Aging Services and Advocacy for LGBT Older Adults," by Loree Cook-Daniels (2004), available at [http://www.forge-forward.org/handouts/future\\_aging\\_sage.php](http://www.forge-forward.org/handouts/future_aging_sage.php)



## Think about universal design

View the elders who are most different from your program's current "average client" as the valuable resources they are. Re-design your system or program to meet *their* needs, and you will automatically better meet the needs of *all* of your clients.

Who that "most different" elder is is going to vary depending on your program. For example, domestic violence and sexual assault programs moving into elder abuse work need to look at the needs of male survivors, since they have been designed to serve the needs of women. Programs set up specifically for LGBT elders need to look at making their space welcoming to heterosexually-identified transgender persons and their partners, since people in LGBT programs tend to see heterosexuals as "not like us" and, therefore, unwelcome.<sup>10</sup>

## Remember that the cultural constant is change

How many of us are old enough to remember when some people thought Italians weren't white people? Which "race" Italians belong to is no longer a question, nor is whether it would be okay to put a Roman Catholic in the Oval Office. Instead, Americans are currently debating whether we can elect a female, African-American, or Mormon President. Like the first two questions, these issues are time-bound; sooner or later, they will be irrelevant and even sound strange.

Someone who lived through the McCarthy Era is likely to have a very different feeling about online blogs than will the 20-year-old who has spent the last six years documenting her every move in a medium available to millions, and who now puts a link to her online video resume adjacent to the pictures she took at her last party.

People are the result of their history and their identities, but these are always changing. So those of us who are creating systems and delivering services must *always* be aware that we cannot put our finger on "what it is like right now to be an elder." We are all in transition from one cultural norm to another, and we can learn much from the experience of "minority" elders who have lived through even more wrenching changes.

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<sup>10</sup> For a longer discussion of what LGBT aging programs need to do to truly welcome their "T" constituents, see "Is Your 'T' Written in Disappearing Ink? A Checklist for Transgender Inclusion," by Loree Cook-Daniels (2001). Available at <http://www.forge-forward.org/handouts/InclusionChecklist.pdf>



## Know what it is you need to know, and ask *that* question

Many aging network intake forms ask people if they are “married.” In a world where there are both state-recognized gay marriages and the federal Defense Of Marriage Act (DOMA), this question no longer tells us anything (if it ever did). What is it that you really need to know? Some of the possibilities are:

- Do you have a caregiver?
- Is there someone you want us to notify in an emergency?
- Do you live alone?
- Might you have insurance coverage under a partner’s policy?
- If you were hospitalized, might anyone challenge your partner’s right to visit you?
- For program eligibility purposes, do we count your partner’s income?
- Are your legal affairs (durable power of attorney, will, etc.) in order?
- If you were widowed, would you be eligible for survivor’s benefits?
- Are you sexually active?
- Who provides your emotional support?

The marital status of someone is only one of the generic questions we routinely use that give us little, if any, useful information. For instance, most “transgender” elders say they are either female or male, which means that even those progressive organizations that have forms permitting a gender designation other than female or male may vastly undercount their transgender constituents.

We need to be careful to ask exactly what it is we need to know. We also need to share with our clients why we are asking for this information. Members of stigmatized communities are often very aware of how personal information can be used against them, and they need to be told why it may be in their best interests to share information they might normally keep private in self-protection.

## Partner with your clients

No one knows better how to deal with systems that exclude or are prejudiced against them than are members of minority groups. Chances are very good that a transgender elder will have an opinion on where he or she should be placed in sex-segregated programs, for example. Providers who differ from their clients on some key demographic variable and are worried about how to accommodate the difference should honor the superior knowledge their client has in this arena by asking for their advice.



Similarly, on a systemic basis, the aging network needs to be partnering with its clients - particularly its “minority group” clients - in order to begin developing the knowledge and systems that will help us develop a world that is supportive of all components of mental health. The days of seeing “mental health” as something that is addressed solely in therapists’ offices are rapidly receding. The aging network has a golden opportunity to embrace this challenge and help something new and far better to emerge.

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