

LGBT AGING: THE APPROACHING SILVER WAVE

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Submitted to the Graduate Faculty of
Behavioral and Community Health Sciences
Graduate School of Public Health in partial fulfillment
of the requirements for the degree of
Master of Public Health

University of Pittsburgh

2016

UNIVERSITY OF PITTSBURGH

Graduate School of Public Health

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ABSTRACT

Over the next twenty to thirty years, nearly four million LGBT Baby Boomers will be retiring and begin using the aging services in the United States. This thesis presents a critical literature synthesis that examines the public health significance of LGBT seniors' health disparities and health protectors, the historical framework that has shaped their lives, and the structural issues that create health disparities. Unique aspects of subgroups within the LGBT population are extrapolated as well. The three major recommendations to support LGBT seniors are: 1) Improve LGBT research to gather more nuanced information on LGBT seniors including the intersection of sexuality with other minority statuses, 2) Support aging-in-place for LGBT seniors to give them a safe, supportive environment surrounded by self-selected friends and family, and 3) Improve and implement LGBT sensitivity training for medical and support groups working with LGBT seniors.

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1.0 INTRODUCTION

Nearly four million lesbian, gay, bisexual, or transgender (LGBT) Baby Boomers will be retiring over the next twenty to thirty years (Anetzberger, Isher, Mostade, & Blair, 2006; MetLife Mature Market Institute & American Society on Aging, 2010) and will begin using aging services in the United States. Others estimate the number of LGBT seniors preparing to retire to be as high as six million with 120,000-300,000 of this total needing to reside in nursing homes across the United States (Bell, Bern-Klug, Kramer, & Saunders, 2010).

LGBT Baby Boomers have been more open than prior generations about their sexuality both at home and in the workplace (Schope, 2005). Encouraged by positive social and legal changes for the LGBT population in the United States such as marriage equality and full federal benefits, this cohort will likely advocate for and demand equal treatment in health and social services (Hughes, Harold, & Boyer, 2011). This generation of LGBT seniors expects to be treated with dignity and respect by healthcare providers, which may be due to the self-advocacy and resiliency noted within the LGBT population (MetLife Mature Market Institute & American Society on Aging, 2010; Van Wagenen, Driskell, & Bradford, 2013). We can infer that health care providers and aging organizations will need to modify their outreach and programming in order to meet the needs of LGBT seniors.

In order to better understand the public health needs of LGBT seniors, this thesis presents a critical literature synthesis that examines LGBT seniors' health disparities and health

protectors, the historical framework that has shaped their lives, and the structural issues that create health disparities. Unique aspects of subgroups within the LGBT population will be extrapolated as well. The thesis will culminate with a set of recommendations and a future research agenda to improve the health of the aging LGBT population.

The social-ecological model will be used in this thesis as a framework to explore the factors that affect the health and wellbeing of LGBT seniors, leading to recommendations to support this population. The social-ecological model examines the interplay between individual, relationship, community, and societal levels that influence health. The individual level includes a person's biology, age, education, minority status, and the like. The relationship level involves spouses, friends, and family. The community level is comprised of employment, neighborhoods, and other settings. Finally, the societal level includes cultural norms, health policies, and social policies that affect the promotion or obstruction of individuals and groups (Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emlet, & Hooyman, 2014).

2.0 BACKGROUND

The social-ecological model examines the interplay between individual, relationship, community, and societal levels that influence health. Many of the major health disparities for LGBT seniors are influenced at the relationship and community levels as they involve the impact of interpersonal relationships, the neighborhood environment, employment, and health care. The health disparities include psychological distress, disability, discrimination, and lack of access to aging and health services (Foglia & Fredriksen-Goldsen, 2014).

Overall health disparity predictors at the relationship level include loneliness, low self-esteem, internalized homophobia, and victimization (Fredriksen-Goldsen & Muraco, 2010). LGBT Baby Boomers, born between 1946 and 1964, are twice as likely as their heterosexual counterparts to live alone (MetLife Mature Market Institute & American Society on Aging, 2010). Living alone has been linked to poor mental health and cognitive impairment (Fredriksen-Goldsen et al., 2012) as well as lower levels of support after hospital discharge (Graham, Ivey, & Neuhauser, 2009).

Data from the California Health Interview Surveys have shown that aging gay men and lesbians have higher rates of psychological distress than their heterosexual counterparts (Wallace, Cochran, Durazo, & Ford, 2011). However, those who live with a partner reported better physical and emotional health and less loneliness (Grossman, D'Augelli, & Hershberger, 2000). Proponents of same-sex marriage could view this as a reason to support marriage equality.

Compared to their heterosexual counterparts, LGBT seniors are more likely to live alone (33% vs. 18%), less likely to be in a relationship (61% vs. 77%), less likely to have children (8% vs. 24%), and more likely to have a disability (41% vs. 35%). These factors increase their risk of being placed into assisted living facilities (Fredriksen-Goldsen et al., 2011; MetLife Mature Market Institute & American Society on Aging, 2010) because LGBT seniors have less social support from close relations which would allow them to age in place compared to their heterosexual peers.

It is important to note the differences in the social care network hierarchy for heterosexual and homosexual persons. The heterosexual hierarchy of care that is available to an individual is usually spouse, then adult children, followed by other relatives, and finally neighbors and friends. The hierarchy for a homosexual person has a different ranking order: spouse/partner, then friends and neighbors, followed by children, other relatives, service providers, and finally parents (Brennan-Ing, Seidel, Larson, & Karpiak, 2014; Croghan, Moone, & Olson, 2014). Since LGBT older adults are less likely to have an available caregiver than the general population (Croghan et al., 2014), the social network of friends and neighbors of LGBT seniors is extremely important because this social network is often the primary care support when LGBT seniors do not have a spouse or partner.

Facing discrimination or a lack of familial acceptance, LGBT seniors have been shown to build their own supportive social networks wherein 90% of the people comprising their social networks are aware of the person's sexual orientation and two-thirds of their social network are gay (Grossman et al., 2000). Many gay people create families of choice from their friends for support in lieu of family members who are not accepting of their sexuality (Fredriksen-Goldsen & Muraco, 2010). Unfortunately, only 40% of LGBT seniors feel comfortable revealing their

sexuality to those considered acquaintances, suggesting that they may not be positioned to create supportive care networks for themselves (D'Augelli & Grossman, 2001).

Contributing to the negative health outcomes of LGBT people is sexual minority stress. Sexual minority stress is the perceived fear and stigma of discrimination or stress reactions to past experiences that can contribute to the negative health outcomes of sexual minorities by creating barriers to care (Porter & Krinsky, 2014; Wight et al., 2012). Sexual minority stress can produce stigma attached to sexual orientation and excessive HIV bereavements. Mitigating factors include having a partner, self-efficacy, and emotional support (Porter & Krinsky, 2014). Because of the stigma of HIV, we can infer that one's HIV status could be a factor in a person's sexual minority stress.

Overall health protectors at the community level include higher social status and class (Fredriksen-Goldsen & Muraco, 2010), increased social support (Fredriksen-Goldsen & Muraco, 2010; Sullivan, 2014), and community involvement (Fredriksen-Goldsen & Muraco, 2010).

Health care is a major area of concern for the LGBT senior population. Among LGB respondents, 42% reported negative experiences with the health care system due to their sexual orientation (Orel, 2014). A 2010 survey by Lambda Legal found that 8% of LGB respondents reported that they had been denied health care because of their sexual orientation. Nearly 15% of LGBT seniors were concerned about accessing health care services outside of the LGBT community. One-quarter have not revealed their sexual orientation to their doctor, and 13% have reported being denied health care services or receiving poor care due to their sexual orientation or gender identity (Foglia & Fredriksen-Goldsen, 2014).

For those who have access to care, HIV has become more like a chronic disease instead of the automatic death sentence that it used to be. Older LGBT individuals with HIV are showing

similar survival rates to those without HIV (Lim & Bernstein, 2012; Rodger et al., 2013) due to the introduction of cART (combination antiretroviral therapy) in 1996. cART is defined as the use of at least three antiretroviral drugs from at least two different drug classes to preserve immune function and delay the progression of HIV (Emlet, Fredriksen-Goldsen, & Kim, 2013).

HIV policies at the societal level have an effect on LGBT seniors. The federal government recommendations for routine HIV/AIDS screening only go up to age 64 (Centers for Disease Control, 2006) despite the fact that half of the 1.1 million Americans living with HIV are 50 years old or older (Fredriksen-Goldsen et al., 2011) and that 17% of new infections occur in people over the age of 50 (Brennan-Ing et al., 2014). Being over the age of 64 does not preclude one from becoming HIV+.

LGBT older adults who are HIV+ were significantly more likely to use health care case management (61%) than their heterosexual peers (12%) (Brennan-Ing et al., 2014). However, 19% of HIV-positive patients reported that they had been denied health care due to their HIV status (Lambda Legal, 2010). Comorbidities, limitations in activities, and victimization are significant risk factors for decreased physical and mental health-related quality of life in gay and bisexual men living with HIV (Emlet et al., 2013). Functional status and comorbidities predict a person's physical health-related quality of living more significantly than AIDS status. Likewise, social support is a predictor of mental health-related quality of living (Emlet et al., 2013). It is reasonable to infer that these findings would apply to LGBT seniors.

At the community level, multiple studies have shown that the majority of LGBT adults want LGBT-specific support groups and socialization (Czaja et al., 2015; Fredriksen-Goldsen & Muraco, 2010; Gratwick, Jihanian, Holloway, Sanchez, & Sullivan, 2014; Portz et al., 2014) and are dissatisfied by services that are not LGBT-specific (Orel, 2014). Over 50% of older LGB do

not have adequate services to help with their physical and psychological needs (Fredriksen-Goldsen & Muraco, 2010). One successful model of service provision is the Los Angeles Gay and Lesbian Center which takes a three-pronged approach to service: socialization opportunities, supportive case management services, and LGBT trainings for service providers. Socialization includes friendly visits to LGBT seniors by younger gay people, facilitating intergenerational contact that each group otherwise would not have. Case management includes aging services that help LGBT seniors plan for their retirement and age-in-place when possible (Gratwick et al., 2014). Aging services for LGBT seniors need to be improved as this large wave of LGBT seniors approach and enter retirement.

2.1 LGBT RETIREMENT NEEDS

A 2015 study by Czaja et al. found that a quarter of the gay and lesbian older adults in their sample had not thought about their future care and expressed concern that no one would be available to support them. A study by Orel (2014) revealed that 22% of LGB respondents faced sexuality-related discrimination when searching for a retirement community. Lack of planning could force LGBT seniors into an assisted care facility that may not be welcoming to the LGBT population.

LGBT-specific retirement communities and nursing homes are almost non-existent in the United States (Fredriksen-Goldsen et al., 2012; Haber, 2009). While LGBT friendly accommodations would be overwhelmingly welcomed by LGBT seniors (Addis, Davies, Greene, Macbride-Stewart, & Shepherd, 2009; Johnson et al., 2005; Knochel, Quam, & Croghan, 2011; Neville & Henrickson, 2010), limited available public funding for aging services likely prohibits

separate LGBT-specific services (Knochel, Croghan, Moone & Quam, 2012). Forty-four percent of LGBT older adults indicated that they were very/extremely interested in LGBT-friendly housing developments (Services & Advocacy for Gay, Lesbian, Bisexual & Transgender Elders [SAGE], 2014). LGBT continuous care retirement communities (CCRCs) would allow LGBT residents to have a range of services available on site (independent living, assisted living, and nursing home care) which would allow residents to stay within their community regardless of their needed level of care. However, CCRCs can require large deposits and monthly fees, so this would not be an option for every LGBT senior (Gabrielson, 2011).

LGBT discrimination in non-LGBT residential care facilities can begin at admission intake if admission forms ask for an opposite-sex spouse or for a list of family members from whom the person may be estranged. The network of close friends that they have built, which they consider their “family,” may not fit into the categories on existing forms (Bell et al., 2010). For these reasons, many LGBT seniors do not tell the long-term care staff of their sexual orientation. They fear that they will face discrimination or exclusionary treatment (Brotman & Ferrer, 2015), so they may not correct staff when they refer to their spouse as their “friend” or “roommate” (Jablonski et al., 2013).

This careful façade could crumble for LGBT seniors who have dementia. These LGBT seniors are faced with the intersection of sexuality, stigma, and sickness (McGovern, 2014). Those afflicted could unknowingly and unintentionally out themselves in an assisted care facility. Boundaries that they may have constructed to protect themselves could be erased without their understanding of what they are doing or the possible ramifications.

2.2 UNDERSTANDING LGBT SENIORS' LIFE COURSE

A life-course perspective focuses on understanding the interactions among people as well as the societal structures (home, work, friendships) they inhabit in order to understand and evaluate their experiences. A life-course perspective considers both the life span and the life stage. In order to understand the health outcomes and behaviors of LGBT seniors, we must understand the social and historical environment for each cohort. “[A]ging is shaped by social context, cultural meaning, and structural location as well as how time, period, and cohort affects age-related transitions and aging processes for individuals and social groups” (Fredriksen-Goldsen & Muraco, 2010, p. 2).

The Greatest Generation, born between 1901 and 1924, was shaped by the Great Depression when the primary concern was day-to-day survival due to the financial crash. The Silent Generation, born between 1925 and 1945, grew up in the McCarthy Era when same-sex behavior and identification were considered criminal acts and mental illnesses. The Baby Boom Generation, born between 1946 and 1964, was influenced by the 1960s Civil Rights Era, the Women’s Rights movement, and modern Gay Rights movement that began with the Stonewall riots in 1969 (Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emler, 2015). Gay men and lesbians ages 65 and older are far less likely to be open about their sexuality than gay men and lesbians in their fifties (Haber, 2009) which can have an impact on health interventions.

The Greatest Generation and the Silent Generation may want more privacy and less acknowledgement of their sexuality while the Baby Boomers may be more comfortable in expressing their sexuality and have expectations to be treated equally and fairly. Understanding these distinct bands of historical experiences may help to provide insight in promoting successful aging among LGBT seniors of differing ages (Fredriksen-Goldsen et al., 2015).

With nearly four million LGBT Baby Boomers retiring over the next twenty to thirty years (MetLife Mature Market Institute & American Society on Aging, 2010), it is important to understand their particular history. Baby Boomers were 5-23 years old when the Stonewall Riots started, which is widely credited as the catalyst for the Gay Rights movement. Baby Boomers were 9-27 years old when homosexuality was removed from the list of mental or personality disorders in 1973 by the American Psychiatric Association, followed by the American Psychological Association in 1974 (Johnson, Jackson, Arnette, & Koffman, 2005). Haber (2009) argues that these two events occurred early enough in this cohort's life cycle to have a dramatic impact on their attitudes, behaviors, and way of living. LGBT people had been marginalized and criminalized for years, but the LGBT Baby Boomer cohort became the first LGBT cohort to gain social and political enfranchisement as they fought to be recognized and equalized with their heterosexual peers.

The LGBT Baby Boomers were 18-36 years old when the CDC first used the term AIDS in 1982. This young cohort lived through the AIDS epidemic at a time when they were in the highest HIV/AIDS risk group and almost nothing was known about transmission causes. Those who survived did so with great loss to their social networks. By 2002, approximately 460,000 U.S. adults had died from AIDS or AIDS-related causes. Of this number, 400,000 were adult males (87%) (Fredriksen-Goldsen et al., 2015). The Gay Rights movement that started with Stonewall was refocused by the AIDS epidemic into caring for the sick, obtaining government funding, and humanizing the LGBT community (Haber, 2009).

When the Defense of Marriage Act (DOMA) was signed into law in 1996, Baby Boomers were 32-50 years old. They were 39-57 years old when the Supreme Court ruled in 2003 that sodomy laws were illegal. In 2009, when Baby Boomers were 45-63 years old, Congress added

the LGBT designation to hate crime legislation. Finally, the Supreme Court ruled in 2015 that same-sex marriage was legal, marking marriage equality for all people regardless of their sexual orientation. The Baby Boomers who were 5-23 years old when the Stonewall Riots took place were now 51-69 years old with the legal right to be married. They are also LGBT seniors.

2.3 STRUCTURAL ISSUES FOR LGBT SENIORS

LGBT individuals can encounter homophobia and heterosexism in their daily lives. Homophobia is prejudice against LGBT people, and heterosexism is the institutional discrimination and systematic oppression by the heterosexual population against LGBT people. Embedded within heterosexism are microaggressions. Microaggressions are “brief, daily assaults on minority individuals, which can be social or environmental, as well as intentional or unintentional” (Foglia & Fredriksen-Goldsen, 2014, p. 4). Examples include coworkers assuming that a person is heterosexual, assuming that a person has an opposite-sex spouse, or calling a person’s same-sex spouse their “friend.”

The cumulative effect of microaggressions and other nonconscious biases negatively alter the way in which LGBT people make health decisions for themselves. If they disclose their sexuality to care providers, their medical treatment will likely be more informed. However, by disclosing their sexuality, they risk opening themselves up to possible negative treatment by healthcare providers who may have nonconscious or overt biases or toward LGBT individuals. Compounded with ageism, LGBT seniors have real barriers to their healthcare (Foglia & Fredriksen-Goldsen, 2014). While LGBT research tends to be concentrated on gay, white, middle-class men, research does exist on some LGBT subgroups as follows.

2.4 TRANSGENDER

The global transgender population is estimated to be 4,000,000-12,000,000 people (Witten, 2015). An examination of the transgender respondents, ages 50 and older, to the Caring and Aging with Pride research project showed that they had poorer physical health than the general, heterosexual population. They also had higher rates of disability, depressive symptoms, and perceived stress (Fredriksen-Goldsen et al., 2011; Fredriksen-Goldsen et al., 2013). Transgender people attempt suicide at a rate of 41% vs. 1.6% for the general population (Grant et al., 2011), which is a staggering number. The intersection of being transgender with another marginalized identity (race, ethnicity, income level, disability) often increases health disparities (Fredriksen-Goldsen et al., 2013).

Transgender people who have transitioned often struggle to maintain employment, having twice the rate of unemployment as the general population (Grant et al., 2011). In light of this, we can infer that transgender people have less access to insurance than their heterosexual or LGB peers. At least 27% of transgender people report having been denied health care (Lambda Legal, 2010), but this rate has been reported even higher at 40% in a 2013 study by Fredriksen-Goldsen et al. (2013). In a national study, nearly half of transgender people identified discrimination (either sexual orientation or gender identity) as their primary aging concern (Knochel et al. 2012).

When transgender seniors and their families look for health care, they are often subject to ignorance, hostility, and discrimination (Giammattei, 2015). Most providers lack knowledge and training on transgender health issues and rarely encounter transgender individuals (Fredriksen-Goldsen et al., 2013). Half of the respondents to the 2011 National Transgender Discrimination Survey reported that they had to teach their medical providers about transgender care such as the

importance of preventative procedures (Grant et al., 2011). For example, a transgender woman may need a prostate exam, and a transgender man may need a pelvic exam. We can infer that transgender individuals may spend more time and money to find qualified and dignified health care than non-transgender individuals.

While homosexuality is no longer considered a mental disorder, being transgender is classified as gender dysphoria, formerly gender identity disorder (Giammattei, 2015), per the DSM-5, the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (Erdley, Anklam, & Reardon, 2014). Before transgender people can have Gender Confirmation Surgery (GCS), they are required to be assessed and diagnosed with gender dysphoria in order to receive a certified document stating that GCS is medically and psychologically necessary. Even with GCS, many will have difficulty changing their gender on their identifying documents (Haber, 2009). This could lead to discrimination in daily interactions such as job interviews and air travel if their gender does not match their identification.

2.5 LGBT AFRICAN-AMERICAN SENIORS

LGBT African-American seniors have lived through Jim Crow, the Civil Rights era, and the Gay Rights movement (Woody, 2014). Woody's interviews (2014) with African-American gay and lesbian seniors identified major themes of concern: a) alienation from the African American community, b) being closeted, c) aversion to LGBT designations, d) alienation and discrimination from religious communities, e) aging-related grief and loss, f) isolation, and g) fear of dependence (financial or physical).

Despite fighting for civil rights and gay rights, many LGBT people within the African-American community do not feel that their sexuality is accepted, so they hide their sexual orientation in order to prevent losing any support from within their community. Loss of support from the African-Americans community has been shown to lead to depression and isolation for LGBT African-American seniors (Woody, 2015). For African-American lesbians, the word lesbian is perceived as a negative word that separates them from being a member of the African-American community. Sexuality can be viewed as secondary to ethnicity.

2.6 LESBIANS

Lesbians are more likely to have partners (Brennan-Ing et al., 2014; Fredriksen-Goldsen & Muraco, 2010; SAGE, 2014), larger social networks (Brennan-Ing et al., 2014; Erosheva, Kim, Emlet, & Fredriksen-Goldsen, 2016; Fredriksen-Goldsen & Muraco, 2010), and live with others (Fredriksen-Goldsen & Muraco, 2010; SAGE, 2014). They were less concerned than gay men about having someone to care for them or having LGBT community activities (Czaja et al., 2015). This may be due to lesbians having a more robust social network than gay men (Fredriksen-Goldsen et al., 2011).

Lesbians expressed concerns about discrimination, coming out, losing their partners, lack of LGBT-knowledgeable medical providers, and legal and financial issues (Czaja et al., 2015; Fredriksen-Goldsen & Muraco, 2010). They have higher rates of alcohol use, smoking, and obesity than heterosexual women, which could lead to higher rates of cancers and other chronic diseases. They are also less likely to use preventative health services such as Pap smears or mammograms (Fredriksen-Goldsen & Kim, 2015; Gabrielson, 2011). A survey of lesbians found

that 80% have faced discrimination in healthcare (Fredriksen-Goldsen & Muraco, 2010) which, coupled with lower income, could explain why health care is not being accessed.

2.7 HISPANIC MEN

Hispanic men are less concerned than their non-Hispanic counterparts about a lack of family or social support, isolation, or lack of training about caregiving. They also did not want LGBT-specific programs; rather, they preferred to be integrated into existing programs (Czaja et al., 2015). The lack of research specifically addressing the needs of Hispanic gay men suggests the fact that this population is poorly understood and likely has unique and perhaps significant health needs.

2.8 RURAL LGBT SENIORS

Rural LGBT respondents were more guarded about their sexual orientation than urban LGBT respondents (Lee & Quam, 2013). A recent study by Lee & Quam (2013) compared the responses between rural and urban participants in the 2010 MetLife Mature Market Institute's "Still Out, Still Aging" survey. In particular, they compared levels of outness and self-acceptance, levels of family support for LGBT identity, number of close friends, household income, and asset levels. Rural LGBT respondents reported lower levels of outness and importance of LGBT identity than their urban counterparts. However, they reported the same

levels of social and family support. The reported sexual orientation for rural vs. urban population was 32% vs. 62% gay, 31% vs. 25% lesbian, and 38% vs 13% bisexual.

3.0 METHODS

This thesis will be a critical literature synthesis of relevant research and programs on LGBT aging and associated health disparities, including recent federal policy changes. I will examine what we already know, discuss the gaps in knowledge and research, and provide recommendations for future work to support LGBT seniors.

I searched journal articles on December 30, 2015, in PubMed and Scopus using the terms LGBT and aging. The searches pulled 49 and 60 results respectively. An additional search on Web of Science using the same search terms was conducted on February 12, 2016. Articles were excluded that focused primarily on youth, were outside the United States, or were outside the scope of the thesis. Additional articles were found through the reference lists of these articles. My prior research from 2013 and 2015 is also included whereby PubMed was also utilized with the search terms gay and aging. Snowball citation sampling was also used in this research.

4.0 RESULTS

The results are interpreted using the social-ecological model and grouped from the macro-level to the micro-level. The results descend in the following order: societal, community, relationship, and individual. While listed under the Societal Level, Aging Trainings and Aging Support Services contain aspects at the Relationship Level that encourage and support the successful building and maintaining of supportive relationships that have been shown to be health protectors.

4.1 SOCIETAL LEVEL

4.1.1 Federal Policy Changes for the LGBT Community

4.1.1.1 DOMA and Marriage Equality

On June 26, 2013, Section 3 of the Defense of Marriage Act (DOMA) was struck down by the Supreme Court because the law denied same-sex couples their Fifth Amendment right of “equal liberty” to marry. This change in law allowed the federal government to extend federal benefits to same-sex couples who were married in any state where same-sex marriage was already legal. Federal benefits such as Social Security, Medicaid, Medicare, military benefits, death benefits, and estate taxes could be applied equally for the first time (Peralta, 2013).

Two years later, on June 26, 2015, the Supreme Court ruled that the right to marry for same-sex couples was guaranteed under the Equal Protection clause of the Fourteenth Amendment, which forbids states from denying any person within its jurisdiction the equal protection of the law. Same-sex couples had the right to marry, just like heterosexual couples, and all federal and state benefits would be required to be applied equally (Chappell, 2015).

Marriage equality allows same-sex couples to receive each other's pensions and Social Security upon one of their deaths. Medicaid and long-term living benefits have been extended as well as the elimination of tax penalties from inheriting estates and property (Erdley et al., 2014). These benefits may help married LGBT people, particularly married LGBT seniors, stay out of poverty and with the health protections of Medicaid.

4.1.1.2 Affordable Care Act

The Patient Protection & Affordable Care Act (known as the Affordable Care Act, ACA, or Obamacare) is providing solutions to certain barriers that prevent LGBT people from accessing and keeping health insurance and services. Nondiscrimination protections based on sexual orientation and gender identity have been added to insurance policies. Prevention and wellness services have been added which will benefit the LGBT population. The removal of lifetime caps on insurance benefit those with HIV, and they can no longer be denied coverage based on their preexisting condition. Low-income LGBT people are now eligible for Medicaid coverage (National LGBT Health Education Center, 2013). Having access to affordable health care earlier in one's life can translate to better health outcomes in later life.

Through the ACA, the Department of Health and Human Services has instituted a "LGBT Data Progression Plan" to add sexual orientation and gender identity questions to federal

population health surveys. In 2013, a question on sexual orientation was added to the National Health Interview Survey, and a gender identity question is being developed (National LGBT Health Education Center, 2013). Having more information and better statistics on the LGBT population will help to tailor health interventions and programs where they are needed.

4.1.1.3 Administration on Aging (AoA) & Older Americans Act (OAA)

Since 1972, the Administration on Aging (AoA) and the Older Americans Act (OAA) have funded the Congregate Nutrition Services in order to provide congregate meal programs (CMPs) and other nutritional services to people ages 60 and older who are at risk of being placed in assisted care facilities (Porter, Keary, Van Wagenen & Bradford, 2014). These meals are delivered in group settings such as senior centers, churches, and community centers. Those at the highest risk include those who live alone, lack family support, have few or no children, or have one or more chronic health conditions (Porter & Cahill, 2015). Meal programs have been shown to be a vehicle for social support, reducing the effects of social isolation in older people (Porter et al., 2014). LGBT seniors have many of these risk factors in higher numbers than their heterosexual peers. Therefore, congregate meal programs may have protective benefits for LGBT seniors.

While Socioemotional Selectivity Theory (SST) suggests that older adults tend to reduce their social networks to close family relations as they age, LGBT seniors have been found to expand their non-kin networks as they age when LGBT-specific services are provided (Porter et al., 2014; Sullivan, 2014). We can infer that LGBT congregate meal programs may enhance this protective factor by providing more opportunities for social support.

These services are distributed through the State Units on Aging (SUAs) and 655 Area Agencies on Aging (AAAs) to people 60 years and older and their spouses (Porter & Cahill, 2015). A national study of congregate meal programs (CMPs) by Porter and Cahill (2015) revealed that the majority of states (64.6%) target CMPs to a specific racial, ethnic, or cultural minority, but only five states target the LGBT population.

The OAA provides comprehensive aging services for older Americans and assists seniors with staying in their homes and communities as long as possible. Aging networks are directed by the OAA to focus on serving populations with the greatest social need. In 2010, the AoA publicly recognized that LGBT seniors have unique needs that should be addressed. The AoA awarded a grant in 2010 to Services & Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE) which enabled them to create the National Resource Center on LGBT Aging (NRC). SAGE launched the NRC in a partnership with other organizations in order to provide training and technical assistance about LGBT seniors to other groups and organizations (Meyer & Johnston, 2014). It should be noted that the OAA bill has not been reauthorized by Congress since 2011. While the funding remains in place, it has not been adjusted for inflation or to account for the updated population of low income seniors (Cisneros & Weber, 2015).

In July 2012, the Administration on Aging (AoA) stated that “isolation due to sexual orientation and gender identity may restrict a person’s ability to perform normal daily tasks or live independently. Each planning and service area must assess their particular environment to determine which populations to target based on the greatest social need” (U.S. Department of Health and Human Services, Administration for Community Living, 2016).

4.1.1.4 Federal Data Collection

The 2010 Census was the first to include same-sex households in the statistics. The estimated data from 2011 was approximately 600,000 same-sex households. Same-sex households were added to the American Community Survey (ACS) in 2005. The Census Bureau is currently piloting same-sex data collection for the 2020 census (U.S. Census Bureau, 2013). Having a better understanding of LGBT demographics will allow for the better targeting of resources to support the LGBT population.

In 2011, the National Institutes of Health (NIH) asked the Institute of Medicine (IOM) to find ways to improve the limited research on LGBT health. The research agenda they developed focuses on the following: demographics, social influences on health and health care inequities, interventions, and transgender-specific health needs (Institute of Medicine, 2011). Having more research data on the LGBT population and LGBT seniors will help to develop more targeted programs and interventions.

The Healthy People 2020 goals (U.S. Health and Human Services, Office of Disease Prevention and Health Promotion, 2010) include a specific goal to “Improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender (LGBT) individuals.” This goal includes the health and well-being of older LGBT individuals and stresses that the mental and physical health of LGBT people should be evaluated and addressed over the next decade in order to shape future health initiatives.

The 2015 White House Conference on Aging (WHCOA) included LGBT leaders and organizations. The final report supports communities for older adults that are inclusive and culturally responsive with an emphasis on aging-in-place. The report also notes that discrimination increases barriers to good health and health aging (White House, 2015).

4.1.1.5 Federal Legal Protections

The Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act of 2009 extended hate crime protections to sexual orientation and gender identity (U.S. Department of Justice, 2015) with the intention of added legal protections for the LGBT community.

While the Fair Housing Act does not specifically prohibit discrimination based on sexual orientation and gender identity, HIV/AIDS status is covered under disability discrimination. However, an LGBT person may still be protected by the Fair Housing Act because housing providers and lenders who receive HUD funding or FHA loan guarantees may be subject to HUD regulations which ensure equal access for LGBT individuals (U.S. Department of Housing and Urban Development, 2016).

4.1.1.6 Federal Nursing Home Reform Act of 1987

The Nursing Home Reform Act of 1987 established the following rights for nursing home residents. These rights apply to LGBT seniors as well (Klauber & Wright, 2001):

- The right to freedom from abuse, mistreatment, and neglect;
- The right to freedom from physical restraints;
- The right to privacy;
- The right to accommodation of medical, physical, psychological, and social needs;
- The right to participate in resident and family groups;
- The right to be treated with dignity;
- The right to exercise self-determination;
- The right to communicate freely;

- The right to participate in the review of one's care plan, and to be fully informed in advance about any changes in care, treatment, or change of status in the facility; and
- The right to voice grievances without discrimination or reprisal.

4.1.2 Aging Trainings

Porter and Krinsky (2014) showed that LGBT aging training produced significant positive change for aging providers on their knowledge and attitudes toward LGBT seniors. Participants increased their knowledge on resources for LGBT seniors and their families. Post-test, participants who agreed or strongly agreed that intake forms should ask about sexual orientation and gender identity increased from 43.4% to 88.2%. However, these same respondents showed a decrease in feeling comfortable providing services to an openly transgender person. This could be attributed to feeling less confident about supporting transgender needs after understanding those needs better.

Policy changes that prohibit LGBT discrimination and mandate education on LGBT awareness may be more effective than optional training for staff (Knochel et al., 2011). A brief, educational intervention had an immediate, positive effect on residential care staff attitudes toward the sexuality of seniors although the long-term effects of the training were not measured. This study contradicted prior studies that had shown that younger and less experienced staff had more negative and restrictive views of seniors' sexuality than their older and more experienced peers (Bauer et al., 2013). LGBT training that includes useful techniques to convey to elderly clients that it is safe to reveal their sexual orientation can lead to better health outcomes (Smith, McCaslin, Chang, Martinez, & McGrew, 2010).

Education could also help to dispel misconceptions about the sexuality of residents in care facilities whether they were LGBT or heterosexual. A recent survey of undergraduate college students found that 25% believed that sexual behavior stopped being important to older adults (Freeman, Sousa, & Neufeld, 2014). In truth, older LGB adults are often sexually active (Fredriksen-Goldsen & Muraco, 2010) and can remain sexually active (and interested) into their nineties even with a physical illness (Bauer et al., 2013). A 2007 study on the sexual activity of over 3000 adults reported that 73% of respondents aged 57-64 were sexually active, 53% of those aged 65-74, and 26% of those aged 75-85 (Stein, Beckerman, & Sherman, 2010).

In 2009, the US Department of Health and Human Services funded the Howard Brown Health Center in Illinois to develop and distribute a peer-reviewed, six-module curriculum titled, Health Education about LGBT Elders (HEALE). HEALE targets nurses and health care staff and has been shown significantly increase statistical gain in knowledge in each of the six areas: 1. Intro to LGBT seniors; 2. Barriers and disparities; 3. Sex and sexuality; 4. Legal concerns; 5. Transgender community; and 6. HIV and aging. Feedback on HEALE reports that 90% of participants agreed that they gained new insights about LGBT seniors from the training, and pre/post testing demonstrated an average knowledge gain of 15% (Hardacker, Rubenstein & Hotten, 2014).

The LGBT Roundtable of the Central California AAA created a one-day competency training targeted toward service providers. The training had four distinct sections: 1) LGBT 101: general overview of LGBT history, culture, and terminology; 2) Making Services/Agencies More LGBT Friendly: advice on changing paperwork and the physical environment to be LGBT-friendly; 3) Long-Term Care: skilled nursing facilities concerns; and 4) Legal Issues and What

We Need to Know to Advocate: estate planning, pensions, and state laws (Leyva, Breshears, & Ringstad, 2014).

It is important to examine why some agencies may not believe that LGBT trainings are needed. A rationale could be found in a study by Jackson, Johnson, and Roberts (2008) that examined LGBT and heterosexual respondents' perceptions about discrimination toward LGBT individuals. LGBT respondents were more likely than their heterosexual counterparts to believe that LGBT individuals do not have equal access to health care and social services, that LGBT residents of care facilities would be victims of discrimination, that LGBT sensitivity training would benefit staff, and that LGBT retirement facilities would be beneficial to elder LGBT individuals. The discrepancy in the answers of the LGBT and heterosexual respondents' answers could be a barrier to successful educational training and would seem to warrant further examination.

Research is needed to discern whether diversity training compels agencies to provide services and outreach to the aging LGBT community and which training programs are the most effective (Knochel et al., 2012). LGBT individuals from rural areas tend to be more optimistic than their urban peers about the positive impact that LGBT education will have on the staff of residential care facilities. Rural LGBT individuals believe that the origin of LGBT discrimination stems from a lack of familiarity with any gay or lesbian individuals and that staff education and training can solve this (Johnson et al., 2005). Rural LGBT individuals tend to be more closeted than their urban peers, so the onus will be on aging service providers to create an effective LGBT-welcoming environment and outreach program (Lee & Quam, 2013).

4.1.3 Aging Support Services

Social workers are often on the frontline with older adults, so they are well positioned to collaborate with aging agencies to find ways to increase socialization and reduce isolation for LGBT seniors (Erdley et al., 2014; Portz et al., 2014), which, in turn, can decrease the risks of poor health, disability, and depression (Erosheva et al., 2016). It should be noted, however, that the National Association of Social Work code of ethics instructs Social Work students and practitioners to refer LGBT clients to another practitioner if their moral or religious beliefs prevent them from treating them with the same dignity and respect as other clients. This approach has been called unethical as it creates an unequal application of social work principles to clients (Fredriksen-Goldsen et al., 2014).

A survey of nursing home social service directors found that approximately 25% had received a minimum of one hour of LGBT training within the last five years (Knochel et al., 2012). Since most social service directors are not receiving LGBT training, it is likely that their staff is not receiving LGBT training either. As many social service departments are often responsible for educating the staff of other departments, whole organizations may lack any LGBT training (Bell et al., 2010).

A 2011 Michigan study by Hughes et al. sampled direct care aging providers in Michigan to see if they provided any LGBT-specific services or outreach to the LGBT population. The majority (63%) felt that LGBT seniors had different needs from their heterosexual peers. Most of those surveyed (90.6%) said that they felt comfortable working with the LGBT aging population, but the majority (63%) also asked for training on LGBT seniors (in-service training was the most popular option with 45%). In direct contradiction, a majority (61.0%) felt that their existing services were appropriate, and said that there were no current activities to target LGBT seniors

(75%). Slightly more than half conduct no outreach to the LGBT community, and three-fourths have no LGBT-specific materials.

A recent nationwide study of Area Agencies on Aging (AAA) found that less than 8% offer services targeted to LGBT seniors, and fewer than 13% provide LGBT senior outreach despite the majority of AAAs indicating that they would like to provide LGBT senior training. The barriers cited were lack of training and lack of funding sources (Gratwick et al., 2014). Two factors that contribute to LGBT seniors not being recognized by aging services providers are: 1) nondisclosure of sexual minority status, and 2) lack of data collection by service providers on sexual minority status (Gratwick et al., 2014).

A study by Knochel et al. (2012) was the first to examine nationwide Area Agencies on Aging (AAAs) to understand their services, training, and beliefs about serving the LGBT community. This survey examined urban and rural areas of the United States. The study examined six areas:

1. How many agencies offer LGBT specific outreach to seniors?

Targeted services: 7.8% to LGB; 7.2% to transgender; Funded outreach: 12.5% to LGB; 12.2% to transgender

2. What kinds of LGBT training do these agencies (AAAs and SUAs) have?

Funded training: 34.1% on LGB; 31.6% on transgender; approximately 80% were willing to offer or fund training on LGB or transgender

Beliefs: Approximately 60% of agencies believed there was a need to address issues to LGB and T, but 53% did not want to offer separate services; 75% believe that LGB would be welcome by local AAAs and 72% for transgender

3. How many agencies have received requests from LGBT seniors?

31% for LGB; 19% for transgender

4. Is there an association between LGBT training and outreach to LGBT seniors?

Agencies that offered or funded staff training were more likely to offer LGBT-targeted outreach, believe in addressing issues for LGBT seniors, and receive service requests for LGBT seniors.

5. What, if any, are the differences between urban and rural service providers?

Urban areas were more likely to provide services that target LGBT seniors, to provide LGBT training, to be open to providing future trainings, and to address LGBT-specific aging issues. They were significantly more likely to receive service requests for LGBT seniors.

6. What, if any, are the differences, found among aging service providers across geographic regions of the United States?

Southern Agencies were significantly less likely to provide outreach to LGBT seniors, fund training, believe that addressing LGBT issues was necessary, and received far fewer LGBT senior service requests. On the other hand, Western Agencies were significantly more likely to provide outreach to LGBT seniors, fund training, believe that addressing LGBT issues was necessary, and received far more LGBT senior service requests (Knochel et al, 2012).

The scope of training ranged from all staff receiving training on LGBT issues to only one employee attending a conference where LGBT training was embedded within a broad training on diversity (Knochel et al., 2012). Affordable training would be helpful where resources may be scarce or budget barriers may be in place, such as in rural areas and the South. Reasons cited for

a lack of training were limited financial resources, lack of interest, an insufficient number of LGBT seniors, or a lack of understanding of LGBT seniors' needs as distinct (Knochel et al., 2012). A study of twenty-four Denver area aging providers also found that one-third of aging providers were not aware that LGBT seniors had distinct needs (Portz et al., 2014). Education would be useful.

4.1.4 Medical Staff

Nursing is positioned to be an agent in eliminating health and social disparities for LGBT seniors if education and training can be improved (Lim & Bernstein, 2012). A review of the top 10 nursing journals from 2005-2009 revealed only eight articles (0.16% of the total) that focused on LGBT issues. Seven of the 10 major nursing journals had no LGBT focused articles published (Lim & Bernstein, 2012). Major textbooks in nursing schools have a minimal mention of LGBT issues as well (Lim & Bernstein, 2012).

The average medical school allocates less than a half-day of instruction on LGBT issues within a four-year curriculum (Haber, 2009). A 2010 survey of medical schools revealed that medical students received an average of five hours of instruction on LGBT-related content in the entirety of their medical school education (Obedin-Maliver et al., 2011). A 2011 study of 150 medical schools also showed an average of five hours of instruction on LGBT-related topics (Lim & Bernstein, 2012).

The Joint Commission, the accrediting body for health care facilities, issued policy standards in 2009 that require long-term care facilities to respect residents' lifestyles including sexual orientation. In 2011, the Joint Commission published updated standards that prohibit discrimination on sexual orientation, gender identity, and gender expression. These new rules

also ensure that a patient may have access to anyone who he chooses to designate as a support person, regardless of being related or not (Joint Commission, 2011).

Since the Joint Commission's accreditation process covers 21,000 hospitals and health care organizations in the United States, this standard should encourage LGBT-specific training for providers who may resist LGBT training (Knochel et al., 2012) and may also influence training in medical schools and other health care fields.

4.2 COMMUNITY LEVEL

4.2.1 Creating a Welcoming Environment

Research by Croghan, Moone & Olson (2015) is the first survey-based study to explore what LGBT seniors believe are indicative of a culturally competent and welcoming service provider environment. While some of the welcoming signals listed below are controlled at the management level, it is encouraging that the top two welcoming signals (acknowledging a patient's partner and practitioner behaviors) are driven by the individual provider. It should be noted that while staff training is often advocated, it was only ranked eighth in this list. This may be because LGBT seniors are concerned with the outcome of the training, not the training itself, thereby missing the cause and effect of the training. The ten welcoming signals to create an LGBT welcoming environment according to LGBT respondents are:

- 1) **Partner:** Acknowledge the client's partner and treat as a spouse.
- 2) **Practitioner Behaviors:** Practitioner is comfortable discussing LGBT issues and relationships.

- 3) **Intake and Interviewing:** Language is LGBT inclusive and welcoming.
- 4) **On-Site Visual Cues:** LGBT signaling signs, flags, posters, artwork, and other symbols.
- 5) **Language Use (outside of intake and interview):** Nondiscrimination policies in place and associate staff are also welcoming.
- 6) **Marketing and Outreach:** Advertising is LGBT-welcoming and inclusive including website and brochures.
- 7) **Recommendations and Reputation:** Friends and others recommend the provider, or the provider has a reputation for being LGBT-friendly.
- 8) **Staff Training Indicated:** Verbal or written notification that staff has received LGBT sensitivity training.
- 9) **LGBT-Identified Staff Members:** LGBT staff members are employed or the staff are known to be welcoming to the LGBT community.
- 10) **Other:** Endorsement by LGBT organizations. Provider advertises as an LGBT-specific service. The provider is in an LGBT neighborhood.

Other researchers support some of the findings above such as clinical intake forms being gender neutral (Czaja et al., 2015; Gratwick et al., 2014), not assuming that a client is heterosexual (Hughes et al., 2011), and marketing to LGBT seniors. Gratwick further recommends mailing marketing pieces in plain envelopes in order to protect the privacy of those who may not be public about their sexuality (Gratwick et al., 2014).

It is important to be proactive to reach out to LGBT seniors because prior “[n]egative experiences are often shared with others, compounding the reach and durability of negative information and experiences” (Foglia & Fredriksen-Goldsen, 2014, p. 5). Negative experiences

and interactions tend to be relived and then relayed to others and influence future interactions, including those between LGBT seniors and healthcare workers.

4.3 RELATIONSHIP LEVEL

Social support and a robust social network have been shown to serve as protective factors from depression, poor general health, and feelings of social and emotional isolation (Addis et al., 2009; Fredriksen-Goldsen et al., 2012; Van Wagenen et al., 2013). For example, rural LGBT seniors have been shown to create a supportive environment for themselves through their social networks despite being more guarded about their sexual orientation than their urban counterparts (Lee & Quam, 2013). As stated previously, Socioemotional Selectivity Theory (SST) states that older adults reduce their social networks as they age, mainly relying on close, family relationships instead of non-kin relationships. However, LGBT seniors have been found to expand their non-kin networks if LGBT-specific services are provided (Porter et al., 2014).

LGBT seniors are comfortable being open about their sexuality when they feel that they are in a safe environment with chosen friends, family, and acquaintances. However, in unfamiliar surroundings like hospitals or residential facilities, many elderly LGBT patients will avoid disclosing their sexuality. Their social networks are then restricted or eliminated. This contributes to the failure of health care and social care services to meet the health needs of LGBT seniors, leading to care inequality (Anetzberger et al., 2006; Addis et al., 2009; Knochel et al., 2012).

4.4 INDIVIDUAL LEVEL

4.4.1 Successful LGBT Aging

The definition of successful aging is unique to each person. Successful aging can refer to surviving into old age with physical and cognitive functions intact, but it can also mean coping with limitations. Successful aging embodies those who are engaged in their lives and their interests, and it incorporates a person's unique cultural beliefs, gender, race, class, geographic locations, and other influencing factors (Van Wagenen et al., 2013).

Kooden (1997) recognized that most of the life cycle theories for gay people only involved coming out and the formation of a gay identity. He wanted LGBT developmental theory to involve the entire lifespan and created development tasks for successful aging: attitude toward homosexuality, role models, new body image, personal value system, self-esteem, interpersonal relationships, work and play, control over one's life, physical health and AIDS, life planning and adulthood, morality and spirituality, and attitude towards aging.

While Kooden looked at successful aging in terms of aging tasks, Wahler & Gabby (1997) looked for predictors of successful aging. Their research showed the predictors, in order of importance, to be: income and access to financial resources, higher education, having a spouse/life partner, and the act of aging itself.

The Caring and Aging with Pride (CAP) study is the first federally funded nationwide study to examine LGBT aging. The survey of 2,560 LGBT adults, ages 50 to 95, demonstrated that most LGBT seniors are aging successfully and satisfied with their lives. An important strength of LGBT seniors is their connection and outreach to their communities. Nearly 90% of the study's LGBT seniors feel good about their communities and are involved in some type of

leisure activity. Slightly more than half engage in vigorous physical activity, and 80% engage in moderate physical activity. Many (38%) attend church services (Fredriksen-Goldsen et al., 2011; Fredriksen-Goldsen, 2014).

Using the National Social Life, Health, and Aging Project (NSHAP) study, a secondary research team looked at the 4% of respondents who reporting a same-sex sexual relationship (SSSR) to find that sexual minority seniors did not appear to have poorer mental or physical health outcomes than their heterosexual counterparts. They were actually more likely to report better physical health and equivalent mental health, which begs further investigation (Brown & Grossman, 2014).

A recent study by Fredriksen-Goldsen and Kim (2015) found that 98% of adults ages 65 and older answered anonymous survey questions on their sexual orientation (Fredriksen-Goldsen & Kim, 2015) which was a 10% higher response rate on household income. This research support the results of the New Mexico Behavioral Risk Factor Surveillance System (BRFSS) study that showed that people ages 18 and older are more likely to answer questions about their sexuality than about their income (Fredriksen-Goldsen & Kim, 2015). This demonstrates that data on the sexual orientation of older adults can be collected successfully in research, public health, and aging-related surveys.

4.4.2 Crisis Competence and Resilience

Crisis competence and resilience may give LGBT people an advantage over their heterosexual counterparts when it comes to dealing with aging. While it will not protect them from poorer health outcomes, it does give them an advantage in navigating difficult situations.

Fredriksen-Goldsen and Muraco, in their 2010 landmark article “Aging and Sexual Orientation: A 25-Year Review of the Literature,” demonstrated that older gay men and lesbians were not depressed, full of feelings of being undesirable, or fighting the aging process. This reaffirmed research by Wahler and Gabbay (1997) that demonstrated that older gay men were not the stereotype of lonely, depressed, bitter people as portrayed by society before Stonewall. Contrary to these unfounded stereotypes, older gay men and lesbians were no more depressed than their heterosexual counterparts were with a majority rating their mental health as excellent or good (Fredriksen-Goldsen & Muraco, 2010). Furthermore, 80% indicated that they were content with their sexual orientation contradicting the image of self-loathing gays and lesbians. Much of their literature review also suggests an association between openly identifying as gay or lesbian and higher levels of self-esteem and positive adjustment to aging (Fredriksen-Goldsen & Muraco, 2010).

Fredriksen-Goldsen et al. (2015) led the first large study using a Resilience Framework to examine the risk factors and protective factors that contribute to physical and mental health quality of life of LGBT seniors. Due to the unique social and historical circumstances of their lives, LGBT seniors experience unique factors such as managing their sexual identities and a potential lifetime of victimization and discrimination. They examined three age cohorts: ages 50-64, ages 65-79, and ages 80 and above. The oldest age group (80+) experienced the least amount of lifetime victimization and discrimination, but what victimization and discrimination they did incur had a larger psychological effect on them than the other two groups. Being a pre-Stonewall cohort, we can infer that they may have been more deeply closeted which lowered their chances of being victimized, but the incidents that did occur must have been physical or psychological shocks that held more weight due to the legal and social ramifications of the times. Another

protective factor of interest for all three age cohorts is that they have the same levels of education even among older lesbians and bisexual women. Even with limited opportunities for women during these times, we can infer that having an education still meant more opportunity and financial independence (Fredriksen-Goldsen et al., 2015).

Kimmel (1978), in his groundbreaking article “Adult Development and Aging: A Gay Perspective,” argued that the coming out process for gay men forces them to cope with stigma and loss at an earlier age than heterosexual people, thereby giving gay men an understanding for addressing future crises earlier than their heterosexual peers. Kimmel called this dynamic “crisis competence” (p. 117). Crisis competence theory states that the ability to successfully manage one stigmatized identity early in the life course, such as being gay, creates skills that transfer to another stigmatized identity, such as growing old (Orel, 2014). As Kooden (1997) states, “[LGBT people have] already challenged the arbitrary social construction of gender roles and... [t]his great flexibility in gender role definitions may actually allow older [LGBT people] to develop comfortable and appropriate ways to take care of themselves.” (p. 24).

5.0 RECOMMENDATIONS / DISCUSSIONS

The three major recommendations to support LGBT seniors are: 1) Improve LGBT research to gather more nuanced information on LGBT seniors including the intersection of sexuality with other minority statuses, 2) Support aging-in-place for LGBT seniors to give them a safe, supportive environment surrounded by self-selected friends and family, and 3) Improve and implement LGBT sensitivity training for medical and support groups working with LGBT seniors.

5.1 IMPROVING LGBT AGING RESEARCH

LGBT seniors are a largely unstudied population (Brown & Grossman, 2014; Foglia & Fredriksen-Goldsen, 2014; Orel, 2014; Sullivan, 2014), which makes them invisible to policy-makers and to potential policy protections. National funding through the National Institute of Health (NIH) for LGBT research has been miniscule in comparison to the general population. In a review of NIH studies from 1989-2011, only 0.05% of the 127,798 studies were LGBT Health-Related (n=628), and the primary focus was on HIV research. Of the 628 studies that focused on LGBT health, two-thirds did not examine race, and only two studies involved people ages 50 and older (Coulter et al., 2014). To reiterate, only two studies out of 127,798 NIH studies from 1989-2011 focused on LGBT people ages 50+. This statistic directly supports the dearth of overall

research into LGBT seniors compared with the LGBT population as a whole. Access to care, homophobia, violence, homelessness, tobacco use, and obesity within the LGBT population are not being researched (Coulter et al., 2014).

By placing such a low priority on LGBT health issues, and an even lower priority on the health issues of LGBT seniors, the NIH is perpetuating the health disparities that exist for the LGBT population, particularly its older members. The National Institutes of Health (NIH) recognized this research gap and asked the Institute of Medicine (IOM) in 2011 to find ways to improve the limited research on LGBT health. The research agenda they developed focuses on demographics, social influences on health and health care inequities, interventions, and transgender-specific health needs (Institute of Medicine, 2011). Due to the Affordable Care Act, the U.S. Health and Human Services Secretary announced in 2011 that questions on sexual orientation and gender identify would be integrated into data collection efforts by 2013 (Brennan-Ing et al., 2014).

Health and aging surveys rarely include sexual orientation. If they do, they often exclude older people (Brown & Grossman, 2014; Fredriksen-Goldsen & Kim, 2015). Furthermore, most population-based studies only include questions about sexual orientation, but not gender identity, sexual behavior, or sexual desire (Wallace et al., 2011). A prime example is the National Social Life, Health, and Aging Project (NSHAP), which is a probability-based nationally representative study of the sexual behavior of older American adults (Waite et al., 2010). There were no questions on gender identity or sexual identity, so sexual minority data was derived from data on sexual behavior.

Fredriksen-Goldsen and Kim (2015) found the rates of individuals who self-reported that they were lesbians/gay males or bisexuals among adults ages 65 and older to be 0.58% and

0.32%. The 50-64 age cohort reported higher rates at 1.48% and 0.65% respectively. In comparison, the 18-49 year old cohort reported 1.88% and 1.83%. It is important to note the differences in these cohorts. They have gone through different life events that have influenced the way in which they have lived their lives. The younger the cohort, the more open they are about revealing their sexuality. This can be attributed to their particular experiences throughout their cohort's life course.

Many LGBT seniors adapted to societal norms by learning to modify their behavior in order to keep their sexuality a secret. Being closeted helped them to avoid threats to their personal autonomy that could have been life changing, resulting in losing their friends, family, or career. The older the cohort, the less likely they are to report their sexual orientation.

However, these same research gaps have been pointed out for nearly 40 years. In 1978, Douglas Kimmel wrote that representative samples are difficult to obtain and that gay research “[is] skewed toward white, well-educated respondents of relatively high socioeconomic status...of adult gay men” (p. 115). Twenty years later, Wahler & Gabby (1997) in their comprehensive literature review on gay males still found that studies are “[on] white, middle-class, well educated, urban-dwelling men who participate in the gay community...” (p. 5).

A disproportionate number of study participants are middle-income, Caucasian, urban, and educated (Anetzberger et al., 2006; Brown & Grossman, 2014; Haber, 2009; Woody, 2014). Many research studies focus only on gay men and lesbians (Addis et al., 2009) and exclude bisexuals and transgendered people. Many organizations and research articles tend to use LGBT when, in fact, there is very little about transgender people in the research. Comingling the research of each part of the LGBT population is problematic as they are different in their sexual orientation and gender and thus have very different needs. By creating composite results for

LGBT people, their unique experiences are not understood (Wahler & Gabby, 1997). Likewise, rural LGBT seniors are underrepresented in research because recruitment for studies has largely drawn from urban areas that have higher concentrations of LGBT people (Lee & Quam, 2013). They may have different needs.

There are segments of LGBT society that are grappling with more than one minority status. Many research articles do not recognize the privilege of race or gender. “Social science research focuses on gender or race, but often not at the intersection of sexual orientation, gender identity, and aging...” (Woody, 2015, p. 51). Older white lesbians are dealing with the biases of heterosexism, ageism, AND sexism. In addition to these three biases, older black lesbians are also dealing with the bias of racism. These personal characteristics cannot be separated from one another, nor can they be hidden. This is further complicated if an LGBT person is poor, physically disabled, or mentally ill. Research needs to look at the cumulative disadvantage of multiple minority statuses (Gabrielson, 2011).

While the literature about crisis competence discusses how it can be advantageous in helping gay people to navigate other aspects of their lives, the same literature often neglects to examine the interplay of race and gender in crisis competence. Minorities and LGBT women may have a distinct advantage in using crisis competence because they will have utilized it earlier as women dealing with sexism, as racial or ethnic minorities dealing with racism, or both. Failure to examine the intersection of these personal characteristics in the course of any LGBT research is a failure to comprehend the differences within the LGBT community.

There are knowledge gaps in the LGBT aging research that limit information on LGBT seniors in several areas. Many studies are based on convenience samples, small sample sizes, or self-identification (Erdley et al., 2014; Orel, 2014). Orel (2014) found that the most successful

method of recruitment of LGBT seniors was “word of mouth” or “snowballing” because LGBT seniors would introduce researchers to people who they may have never located otherwise due to their not readily being open about their sexual orientation. Among LGBT seniors, there are fewer “out” older adults who are willing to participate in research and interviews than younger LGBT generations, which restricts the amount of available data to determine their needs (Hinrichs & Vacha-Haase, 2010).

The professional literature overall is lacking in LGBT content as well. Gerontology academic fields often ignore LGBT issues (Brown, 2009; D'Augelli & Grossman, 2001; Knochel et al., 2012) and LGBT academic studies often ignore geriatric issues (Addis et al., 2009). A five-year review of nursing literature found only eight out of approximately 5,000 articles on LGBT health. A similar review of conferences attended by Aging Network staff over a seven year period found that eight of 1,136 sessions covered LGBT issues (Knochel et al., 2012).

There are also important differences that need to be recognized within the aging gay population. Many studies on older people do not delineate between the Baby Boomers and older generations (Haber, 2009). This is important to note because older generations are much less likely to have come out of the closet than the Baby Boomers. Since being out is associated with better mental and physical health outcomes, Baby Boomers should have better health outcomes than their older peers, which can be evaluated if the age cohorts are examined.

Rural LGBT seniors are not well represented in research. However, the study by Lee & Quam (2013) compared the responses between rural and urban participants in the 2010 MetLife Mature Market Institute’s “Still Out, Still Aging” survey which showed an interesting difference between the rural vs. urban population in reported sexual orientation. The respondents indicated 32% vs. 62% gay, 31% vs. 25% lesbian, and 38% vs 13% bisexual. The lesbian percentages are

very similar, but the difference in the self-reported gay and bisexual groups would seem to warrant further investigation.

Understanding the health disparities of LGBT seniors is crucial in the development of programs and effective interventions that will improve the health of LGBT seniors. Without accurate data to design these interventions, disparities will continue, and the design of the interventions will be inaccurate.

5.2 LGBT RETIREMENT

Although placement in a nursing home is a major concern of many Americans, only 5% of older adults live in a skilled nursing facility or nursing home (Crogan et al., 2014). LGBT seniors need support resources in order to keep them healthy and in their own homes. Until assisted living facilities have better LGBT training, policies, and outreach, LGBT seniors need support for aging-in-place instead of LGBT-specific retirement communities.

As LGBT people age, they become more reliant on programs and services, some of which may not be of their choosing. For example, when people go into an assisted living facility, they are no longer seen by their primary care doctor, but by the doctor who works for the assisted living facility. For LGBT seniors who may have spent considerable time and effort to build an honest rapport with a doctor who understands their unique needs, this can be a devastating blow. This can lead to social isolation in the assisted living facility and avoidance of acquiring proper health care and social services.

Major cities such as San Francisco and Los Angeles have developed some LGBT-specific housing. Sullivan (2014) surveyed the residents of three LGBT retirement communities on the

West Coast, two of which are now closed. Respondents indicated that they selected these locations because they wanted to feel accepted and have new support networks and friends. The researcher pointed out that the lack of stigma and homophobia can lead to increased feelings of safety for sexual minorities. However, an LGBT-only retirement community does not eliminate stigma or homophobia; it only reduces the opportunity for it to occur. Citing safety as a primary concern for LGBT-specific care facilities also fails to acknowledge that LGBT seniors have lived in and survived in this society for at least 65+ years. They obviously have demonstrated a type of resilience, fortitude, and innovation for navigating overt and covert prejudice through the changing societal attitudes towards LGBT people.

LGBT-specific housing in a few major cities does not address the needs of the majority of LGBT seniors who are in other cities or rural areas (Wallace et al., 2011). There are too few specialized LGBT senior care communities to feasibly house all LGBT seniors. Furthermore, urban areas are more expensive than rural areas, so LGBT seniors who cannot afford to live in a city, who do not want to relocate to another location in general, or who have no desire to live in an urban setting are excluded from existing LGBT-specific senior housing. What are the alternatives?

A solution could be to create senior care communities that have a progressive element. Instead of attempting to group people by sexuality, senior care facilities could be encouraged to advertise that they are supportive of all lifestyles. Those seniors who are not comfortable with such liberal leanings would have counterpart options in the multitude of religious-affiliated care facilities that dominate senior care.

Heterosexism and ageism views need to be dispelled in retirement care. Residents should be able to express their sexuality as long as it does not infringe on the rights of other residents. A

policy that places the monitoring of sexuality at the institutional level removes the responsibility from the staff to decide what is or what is not appropriate. Consenting adults have a right to have a healthy sexual life in their home, whether they are in their own house or a residential care facility.

5.3 CREATING CULTURAL COMPETENCE

Aging providers need to provide culturally competent services for LGBT seniors in order to reduce their fear of discrimination and to encourage them to access needed services. Medical providers, such as doctors and nurses, have little to no training in school on LGBT issues, and their academic journals provide little continuing education. Cultural competence is more than saying that everyone is welcome; it is offering friendly and positive outreach to marginalized or underrepresented groups (Porter & Cahill, 2015). Many agencies would like to offer training, but lack funding. Inexpensive, online trainings need to be created and offered to meet this need, especially in rural areas and the Southern United States. Health care and mental health care providers would benefit from LGBT sensitivity training that would give them a better understanding of the LGBT community's medical and psychosocial needs.

Many social services agencies seem to resist acknowledging that some issues are particular or more prominent in the LGBT senior population. When they comment that services are provided to all seniors, regardless of their sexual orientation, they fail to acknowledge that some of their seniors might be LGBT. When they do not ask for sexual orientation on intake forms, it promotes the fiction that all their clients are heterosexual. This negates the possible

opportunity for aging service providers to have honest interactions with clients which could connect LGBT seniors with appropriate services.

When LGBT people do not feel comfortable sharing personal information about themselves to health care providers that may be relevant to their care, the shared decision-making process is compromised. Shared decision-making is based on patients trusting personal details of their lives to their healthcare professionals in order to create an appropriate plan of care. Shared decision-making relies on the healthcare provider's benevolence, that the provider is truly acting for the benefit of the patient (Tronto, 1993). Acting for the benefit of the patient reinforces the patient's autonomy by enabling the patient to communicate all relevant information to the provider. However, when LGBT patients withhold information because they have been marginalized in the past, healthcare inequities continue to be perpetrated on the LGBT population, particularly LGBT seniors. Health care workers need to create a welcoming, non-judgmental environment that fosters collaboration, not marginalization, with LGBT seniors.

5.4 LIMITATIONS

As this is a critical literature review, not all research or studies have been reviewed and no new knowledge or research has been created. Instead, this thesis attempts to examine research on LGBT aging from multiple sources to broadly understand the current state of the LGBT senior population and how to support them in the future. Interpretation of results is limited by the dearth of research for certain populations, such as Hispanic gay men.

5.5 CONCLUSION

In order to better understand the needs of LGBT seniors, this thesis examines the health disparities of LGBT seniors as well as mitigating factors for good health. The historical framework of LGBT seniors was reviewed to understand the influencing events that shape how they perceive and interact with the world. Finally, the structural issues that create disparities were examined to understand the common barriers to aging successfully.

LGBT centers, community groups, and organizations are in the beginning stages of reaching out to older LGBT people, not because this age group was thought of as unimportant, but because the main LGBT health priority for the last thirty years has been HIV/AIDS. Now that HIV/AIDS has moved from an automatic death sentence to a chronic, manageable disease, and more LGBT people are surviving into older age, there will hopefully be a greater priority and a greater interest in the health and wellbeing of LGBT seniors.

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