Mental Health Counseling of LGBT Elders

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Abstract

This chapter discusses the complexity of mental health among older lesbian, gay, bisexual, and transgender (LGBT) individuals. Mental health issues for LGBT older adults can potentially involve the long-term impact of stigma and discrimination, and the changing view of sexual orientation and gender identity as pathology to non-pathology. This chapter will address both the risk and protective factors that are relevant to mental health counseling of LGBT older individuals, will discuss the history of research and practice related to mental health, and will provide recommendations for creating culturally competent evidence-based training programs for mental health service providers working with LGBT older adults. As well, the chapter provides an overview of specific issues relevant to the LGBT community including depression and anxiety and body image concerns. Interdisciplinary perspectives to service delivery for LGBT older adults are highlighted.

Keywords

LGBT mental health · Mental health counseling · Minority stress theory · Depression and anxiety · Body image

Overview

This chapter provides an introduction to mental health counseling specifically addressing relevant issues for lesbian, gay, bisexual, and transgender (LGBT) older adults. The chapter begins with a broad discussion of mental health and then more specifically examines relevant history that impacts psychological services for LGBT clients.

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Specific psychological issues are presented including depression and anxiety and body image and eating disorders. Potential barriers to accessing mental health services are described as well as how mental health counselors can become culturally competent service providers. This chapter addresses both the risk and protective factors that are relevant to mental health counseling of LGBT older individuals and specifically highlights issues that are unique for transgender older adults. Finally, recommendations for creating culturally competent evidence-based training programs for mental health service providers working with LGBT older adults are provided.

Learning Objectives

By the end of the chapter, the reader should be able to:

1. Understand the risk and protective factors that are important to the mental health of LGBT older adults.
2. Understand the difference between sexual orientation and gender identity in mental health risk factors and outcomes.
3. Understand the history of research and practice related to mental health of LGBT elders.
4. Understand culturally competent evidence-based mental health practice concepts for working with LGBT older adults.
5. Discuss the importance of understanding the developmental risk and protective factors of growing up as an LGBT individual to counselor competency and effective mental health service delivery.

Introduction

Mental health refers to the state of emotional and psychological well-being and is inextricably linked with physical health and quality of life. Mental health of older LGBT individuals is a complex issue involving the long-term impact of stigma and discrimination, the changing view of sexual orientation and gender identity as pathology to non-pathology, and socioenvironmental stress that impacts individual psychosocial resources. Social stress theory and minority stress theory provide well-established frameworks emphasizing how stress can impact an individual's mental health and well-being from extended exposure to discrimination and stigma (Aneshensel 1992; Dohrenwend 2000; Meyer 1995, 2003). Minority stress is based on the premise that, due to stigma and marginalization, LGBT individuals may experience enduring psychological stress (Meyers 2003). Research has documented the negative impact of minority stress on the mental health of the overall LGBT population, including higher rates of mental disorders, substance abuse, and self-harm than heterosexual populations (Cochran and Mays 2000; King et al. 2007; Meyer 1995). However, research has also demonstrated that good mental health outcomes were indicated for those individuals that were "out" (i.e., people knowing about their sexual orientation or gender identity) who had a higher sense of social integration and lower internalized homophobia and transphobia (D'Augelli et al. 2001; Lombardi 2009). As with the heterosexual population, good mental health outcomes for older adults are related to self-acceptance, purpose in life, social support, and financial security. Some studies suggest that LGBT older adults may adjust to aging more successfully than their non-LGBT counterparts, due to increased resilience from dealing with prejudice, stigma, and loss (Gabbay and Wahler 2002; Orel 2004).

Although the term "LGBT" is utilized as an umbrella term, gender identity (transgender older adults) and sexual orientation (LGB older adults) are distinctive from each other with different mental health influences and outcomes. There are numerous reasons why mental health needs based on sexual orientation and gender identity differ, including the history of the categorization of homosexuality and gender identity as diagnosable conditions in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (*DSM*).

History of Research and Practice

The population of 65 and older LGBT individuals came of age during a time when they were considered mentally ill by mental health professionals and as often engaging in immoral and/or illegal by society's standards (Jacobson and Grossman 1996). Therefore, older LGBT individuals developed in a culture of being socially invisible in the twentieth century. This pervasive stigma was a major contributor to the decision for many to follow a "heteronormal lifestyle" or to conceal their sexual orientation/gender identity from family, friends, and employers (D'Augelli et al. 2001).

On the other hand, there was a growing culture shift during the 1960s and 1970s during which society began to embrace more diverse sexualities/identities and emphasized tolerance. Baby boomers—those born from 1946 to 1964—were the first generation to more openly dabble with "alternative lifestyles" (Rubin 2001), a variety of non-traditional family forms, including gay and lesbian relationships, open marriages, and multiple relationships.

History of Sexual Orientation. The development of mental health services for LGB people can be best understood in the context of the tumultuous history and society's ever-changing view of the morality of sexual orientation. Societal and religious objections to same-sex relationships and attraction have existed since at least the Middle Ages (Davenport-Hines 1990). In the 1950s–1980s, the characterization of homosexuality as a mental illness led to the oppression of sexual orientation and encouraged countless people to participate in psychoanalytic and psychiatric treatments to "cure" their homosexual tendencies (Smith et al. 2004). During the early to mid-twentieth century, psychoanalysis was the dominant perspective in psychiatry and argued that homosexuality was a "reparative" attempt to achieve sexual pleasure when a normal heterosexual outlet proved too threatening (Rado 1949). Homosexuality was identified in the *DSM* as an illness until 1973, and conditions pertaining to homosexuality were not entirely removed until 1987.

History of Gender Identity. Gender identity has faced a similar historical background of medical and psychological pathologization. Gender identity was characterized as a disorder until the emergence of the *DSM-V* in 2014, which replaced the term "gender identity disorder" with "gender dysphoria." Although transgenderism is still represented in the *DSM-V*, gender identity has been reclassified from a disorder with the new aim of therapy to assist people to live in the way that best suits their authentic gender.

There is tremendous variation and diversity among transgender individuals in terms of their mental health needs. Because mental health is intrinsically linked to physical, psychosocial, and spiritual health, successful mental health interventions with older transgender individuals require a holistic approach to health that includes both primary and psychosocial cares. Specific issues that impact mental health for transgender individuals include transphobia, the impact of gender issues on psychosocial and identity development, and psychological effects of hormones (Bockting et al. 2006). Refer to Discussion Box 1 for additional guidance on discussing transphobia.

Discussion Box 1
What is your definition of transphobia? Please provide an example, either real or hypothetical.

The LGBT older adult population may still remember a time when medical and mental health professions sexualized and pathologized their identity and behavior. Today, the mainstream view among mental health clinicians is that homosexuality is a normal human expression and is no more inherently associated with psychopathology than is heterosexuality (Herek and Garnets 2007). Although sexual orientation and gender identity are no longer considered disorders, lingering stigma and fear remain as barriers for older LGBT individuals to accessing mental health services.

Psychological Issues

Opinions and feelings about sexual orientation and gender identity are rampant, as are opinions and attitudes about aging. Surprisingly, there is not much empirical literature about aging among sexual minorities; therefore, there are comparatively few studies about the mental health needs of older LGBT people. However, there are a variety of known factors that can impact mental health among LGBT older adults. According to minority stress theory (Meyer 2003), LGBT individuals are at higher risk for psychological problems because they face chronic stressors as a result of their minority status. This can take the form of external, objectively stressful events, the expectation of external stressors, and the internalization of negative societal attitudes regarding their minority status (Meyer 2003). In addition, society is facing an uphill battle against ageism (fear of older people) and gerontophobia (fear of our own aging), as aging anxiety remains pervasive in the USA. Being LGBT and being older can result in "double jeopardy," whereby the older, sexual minority individual becomes even more vulnerable to psychological stressors. Therefore, older LGBT individuals may struggle with issues such as negative self-image and self-hatred, and self-imposed or societal isolation, and perhaps regret for not coming out earlier or at all (Makadon et al. 2008). Being older and LGBT increases obstacles to accessing adequate mental health services in a predominantly youth and heteronormative society (Orel 2004). Refer to the case study below as a guide to discuss what psychological issues can impact an LGBT older adult.

Case Study

Ms. Jones is an elder lesbian whose partner recently passed away. She lives in a rural, conservative community and has experienced increased incidences of anxiety and depression since her partner passed away. What are barriers to successful aging for Ms. Jones?

Depression and Anxiety

The National Alliance on Mental Illness (2014) reports that LGBT people are likely to be at higher risk for depression than their heterosexual counterparts. This statement is also as likely true of LGBT elders, as evidenced by The Aging and Health Report (2010) finding that 31 % of LGBT elders reported having depressive symptoms at a clinical level, with more than half having been told by a doctor that they had depression. In many areas of mental health, people of color and transgender people show higher rates of mental distress as well.

Exposure to stigma, discrimination, and resulting victimization based on sexual orientation and/or gender identity, coupled with ageism and victimization based on age, result in LGBT older adults being vulnerable to depression and anxiety. Evidence indicates that mental health outcomes are associated with the stress of having a stigmatized identity and living in a discriminatory environment (Meyer 2007). In addition, loss and grief can have an impact on mental health, especially if the loss is unacknowledged, which may often be the case with a grieving LGBT older adult (Glacken and Higgens 2008).

Anxiety disorders have received relatively little empirical attention among older adults compared to the research on mood disorders such as depression. However, generalized anxiety disorder (GAD) is thought to be the most common anxiety disorder among older adults (Hybles and Blazer 2003) and is associated with lower quality of life and increased risk of medical conditions (Mackenzie et al. 2011). The cause of depression and anxiety in the LGBT community, and specifically among LGBT elders, can be attributed to a variety of factors that include:

- Societal oppression as a part of a marginalized group;
- A societal norm that encourages the minimization of the LGBT experience;
- Stress specific to living in and navigating a homophobic culture;
- Societal pressures to fabricate an untrue self;

- Internalized oppression/internalized homophobia;
- Isolation;
- Grief/loss/loneliness;
- Denial of true self;
- Low self-esteem.

The diversity of the aging LGBT community requires an understanding of both the historical and social context of their lives. Some are of the "Greatest Generation," who came of age in the shadow of the Great Depression or in the McCarthy era (1950s). Others are of the baby boom generation, who came of age during the era of the civil rights movement (1960s) and the Stonewall riots (1969) (Fredriksen-Goldsen and Muraco 2010). Yet, others are from ethnic minority groups, which adds the influence of race as a historical and social context (see Chaps. 5, 6, 7, 8, 10). Many LGBT elders internalized the oppression, homophobia, and transphobia that have been ever present in our society. The internalization of the prevalent societal thinking regarding the LGBT community and the aging population in general makes it difficult to counter the negative messages with positive attributes. According to the National Alliance on Mental Illness (NAMI 2014), "LGBT people do not by definition have a mental illness, but they have to contend with societal stigma and negative experiences that likely contribute to an increased vulnerability to mental illness" (p. 2). Without family or community support, the hatred can manifest internally, impacting the LGBT older adult's belief about himself and others in his community. However, it is important to note that most LGBT individuals ultimately live happy and healthy lives (NAMI).

It is very likely that many LGBT elders did not have the experience of a positive family support system specific to their sexual orientation/gender identity during their formative years. Depending on the societal norms of the time, LGBT elders more often hid their sexual orientation/gender identity from family and friends, thus limiting important support systems. The lack of this support system and identity building block could have caused increased vulnerability for mental health disturbance, health-related deterioration, and overall decrease in general life well-being. Isolation is another factor that can contribute to an increased risk of mental health disturbance (see Chap. 30 for further discussion on social isolation). Isolation can contribute to loneliness, low self-esteem, and sense of self-worth. Low self-esteem and/or self-worth can create a constant dissonance that can ultimately lead to a path of self-destruction (i.e., alcohol, drugs, risky behaviors, and violence to self and others), which in turn leads to depression and anxiety.

Although becoming a "whole" person can be a lifelong endeavor for most individuals, LGBT older adults who have engaged in this "denial of the true self" for a large percentage of their lives may have trouble attaining their "whole-person" potential during their lifetime. Treatment considerations with LGBT older adults, as with other minority groups, involve assisting the client in working toward self-acceptance. The acceptance of oneself is an important factor in decreasing depression and anxiety in the LGBT community. Use the following case study as a guide to discuss how to address the mental health concerns of an older LGBT individual.

Case Study

Ms. A. is an 82-year-old African-American woman who lives in her home in the community. Once a week, Ms. A. visits a hair stylist and talks about her life. During the course of one conversation, Ms. A. shared that she had never been married and had no children and that she had never felt a part of a "regular" group of people. The information shared led the stylist to believe that Ms. A might be a part of the LGBT community. The stylist, who was also a part of the LGBT community, continued to engage with Ms. A and talk with her about her life. Eventually, Ms. A confided that she was a lesbian. Ms. A also shared that she was no longer in contact with most of her lesbian friends and that she was felt isolated from the LGBT community. Ms. A also discussed feelings of sadness about her social isolation and lack of connection

with people of her age in the LGBT community.

Questions for discussion: If you talking to Ms. A, how would you approach this situation? What would be your concerns about Ms A's mental health? How would you address these concerns?

Protective Factors against Depression and Anxiety. It is important to note that community epidemiological research has consistently demonstrated that the prevalence of major depression decreases with age and is especially low among those 65 and older (Beekman et al. 1999; Blazer and Hybels 2005; Jorm 2000). In addition, LGBT older adults may have protective factors that make them less likely to experience depression or anxiety as a result of stigma and discrimination. For example, Orel (2004) found that many older LGBT individuals demonstrated that the process of "coming out" helped develop psychological resilience that prepared them for psychological issues related to aging. The process of "coming out" may actually buffer LGBT people against later crises, a term called crisis competency (Kimmel 1978). Along with the likelihood of experiencing prejudice and stigma throughout their life, older LGBT people develop coping mechanisms that foster resilience. A sense of resilience brings strength to the aging process. In fact, research has demonstrated that older LGBT people report higher levels of life satisfaction and lower self-criticism (Barranti and Cohen 2000). For a more in-depth discussion of crisis competency, see Discussion Box 2.

Discussion Box 2

Given examples of what life experiences, in addition to coming out, those LGBT individuals may have experienced which support their "crisis competency."

Specific Issues in the older transgender population. Gender dysphoria and gender identity disorder are terms that have been used to describe the pathology associated with the anxiety and sadness that is experienced by those who feel that they are living as the wrong gender. Research has demonstrated that transgender individuals are at higher risk of poor mental health and attempted suicide (Clements-Noelle et al. 2001). Stigma, discrimination, and exposure to transphobia can have a profound impact on the development of mood and anxiety disorders. Transphobia can be described as a feeling of unease toward those who identify as transgender (Hill 2002). The scope and prevalence of discrimination and harassment is well documented in the literature. Studies have reported that it is common for transgender individuals to experience verbal harassment, employment discrimination, economic discrimination, housing discrimination, and physical abuse (Clements 1999; Lombardi 2001; Reback et al. 2001).

Body Image and Eating Disorders

Body image and eating disorders are important topics in relation to the older LGBT population in part because of the belief that these issues are restricted to white upper-class heterosexual girls. Body dissatisfaction has been found to be relatively stable over the life span, with the importance of body image just as salient for older adults as for younger and middle-aged adults (Webster and Tiggeman 2003). In addition, the ideal body image is continuing to become more rigid for both men and women in the LGBT community.

Body image is a multidimensional construct that emphasizes the degree to which individuals are satisfied with their appearance. Perception of one's shape and weight represents an important component of self-concept and self-esteem. Dissatisfaction with one's body can have a number of potential consequences, including disordered eating, depression, and anxiety (Forman and Davis 2005).

Body Image and Sexual Orientation. Recent research has suggested that sexual orientation in both men and women may play a significant role

in body dissatisfaction and the development and onset of disordered eating, as there are a disproportionate number of men with eating disorders that are gay and/or bisexual (Feldman and Meyer 2007). Research has demonstrated that homosexual men are generally more dissatisfied with their weight and more likely to desire an underweight ideal and have more eating disturbances than heterosexual men (Frenchet et al. 1996; Herzog et al. 1991; Williamson and Hartley 1998). Gay and bisexual men are more likely than heterosexual men to view their bodies as sexual objects and therefore may be more vulnerable to experiencing body dissatisfaction (Siever 1994).

Sociocultural perspective is a theory that has been used to describe the presence of body dissatisfaction in the LGBT community. Sociocultural perspective postulates that the social and cultural values that inform the ideas of what constitutes an ideal body image are unobtainable by many (Yager 2000). According to the sociocultural perspective, gay and bisexual men are subject to similar demands and pressures as heterosexual women, which make them more likely to be affected by norms that guide ideal beauty. On the other hand, researchers have found that the application of sociocultural perspective to lesbian and bisexual women has the opposite effect; for example, lesbian and bisexual women may be less prone to eating disorders because they do not share the standards and ideals of feminine beauty embraced by heterosexual women (Feldman and Meyer 2007). However, it is a misnomer that a strong feminist perspective is protection against lesbian and bisexual women having body image concerns. Research on body image and eating disorders among lesbian and bisexual women has produced unclear results. For example, some studies demonstrate stronger associations between body esteem and self-esteem in homosexual women, with increased prevalence of disordered eating (Striegel-Moore et al. 1990; Wichstrom 2006), while others have shown fewer dysfunctional eating attitudes and behaviors in homosexual women (Lakkis et al. 1999; Strong et al. 2000). Clearly, there is more research needed regarding the relationship between body image and eating disorders among lesbian and bisexual women.

Body Image and Gender Identity. There is a dearth of research regarding the relationship between gender identity, body image, and eating disorders. However, eating disorders and body dissatisfaction are related to gender and gender roles (Murnen and Smolak 1997). It has been postulated that the constructs of masculinity and femininity may best explain the relationship between gender roles and disordered eating. In other words, those with more feminine characteristics, regardless of gender, are more likely to experience disordered eating or body dissatisfaction. However, research on gender role and eating pathology is contradictory and difficult to interpret. Although some studies suggest femininity associated with higher levels of eating disorders (Meyer et al. 2001), others reveal that higher masculinity was associated with abnormal eating behaviors (Pritchard 2008). Limited evidence exists supporting a possible relationship between being transgender and having an eating disorder. The limited research that does exist hypothesizes that male-to-female transgender individuals are at great risk of developing an eating disorder.

There is very little research on body image and eating disorders among older adults and almost nonexistent research about body image and eating disorders among LGBT older adults. However, LGBT older adults may be more at risk for issues related to body image and eating disorders than their heterosexual counterparts. With aging come biological changes that effect physical appearance: increased weight, slowed metabolism, graying of hair, and wrinkles. Although there is a developmental phenomenon that promotes a more adaptive body image with age, body image is relatively stable across the life span. Therefore, older adults often age alone with maladaptive body dissatisfaction and disordered eating. A lifelong pattern of a negative body image can be exacerbated by a fear of aging. Fear of aging includes increasing concern about physical appearance and attractiveness. Fear of aging is predominant in Western culture and equates physical beauty with youth. Fear of aging has also

been associated with both body dissatisfactions and disinhibited eating (Lewis and Cachelin 2001). Given that men subscribe more importance to physical attractiveness than women, older gay men are at greater risk of being less satisfied with their bodies and more vulnerable to eating disorders in order to conform to the pressure of physical attractiveness. In a study of gay and lesbian perceptions of aging, Schope (2005) found that gay men feel that gay society views aging as something negative. Interestingly, gay men identified the age of 39 as "old" for a gay man. Therefore, gay men appear to experience increased difficulties sustaining positive self-images in the face of both societal homophobia and judgment from within their own community.

Research Box

Drummond, M. (2006). Ageing gay men's bodies. Gay and Lesbian Issues and Psychology Review, 2(2)60–66.
Title of the Research: Aging Gay Men's Bodies.
Objective: To examine emergent body-based issues for older gay men.
Method: In-depth interviews of three gay males. Results: Emergent themes identify that older gay males have concerns about their body image.
Conclusion: Older gay men experience challenges in regard to their body image, which subsequently impacts identity and self-esteem.
"Amidst a highly commodified consumer culture in which the body is central to youthfulness and vitality, arguably even more so in gay culture, aging gay men are increasingly confronted with such ageist notions."

Barriers to Service Utilization

The LGBT aging community is a growing and diverse population, and careful examination of the current systems and mechanisms of care is needed. As healthcare professionals work toward meeting the needs of all older adults, the aging services network will be challenged to provide competent, fair, and equitable services to the LGBT community. The lives of lesbian, gay, bisexual, and transgender older adults are often obstructed by the barriers they encounter in order to attain mental health services in addition to other services, including medical care, short- and long-term care services, nutritional and physical fitness programs, senior housing, assisted living, in-home health services, legal services, transportation, recreation, and support groups.

In fact, a study by McIntyre et al. (2011) found that the medical model of care contains particular access to barriers for LGBT people. Specifically, study results identified systems-level barriers which include barriers inherent within the medical model that diminish individuality, lack of availability of supportive services including insufficient financial support for LGBT mental health services, and lastly disincentives for trained and culturally competent LGBT providers. As well, fear of discrimination is a significant barrier to the solicitation of mental health services for many LGBT older adults. The stigma of being a target of homophobia, heterosexism, or transphobia is of great concern to LGBT elders. It is not uncommon for an older adult to remain closeted about his or her sexual orientation or gender identity out of fear of insensitivity or lack of understanding which can contribute to disparities in mental health services and treatment (Mays and Cochran 2001; McIntyre et al. 2011).

Another barrier to mental health services for LGBT older adults relates to the professionals' lack of knowledge of the LGBT community, their culture, and lifestyle preferences. Professionals, although well intentioned, may be undereducated, miseducated, or simply not educated concerning the mental health needs of the LGBT community. A negative experience with a health professional, limited availability of LGBT-friendly professionals, and lack of education and support can cause LGBT older adults to shy away from seeking mental health services.

The lack of knowledge of mental health professionals can be particularly salient for older transgender individuals. It is not uncommon for mental health professionals to lack the knowledge about gender identity that is necessary to provide effective person-centered care.

As a result, it often becomes necessary for the older adult to educate his or her own mental health provider or medical healthcare provider about issues related to the transgender experience.

As well, the LGBT community may be disproportionally affected by the ever-rising costs of healthcare services, creating another barrier to the acquisition of mental health services. This is illustrated by the SAMHSA report (2014) estimating that one in three LGBT Americans in the low- to middle-income base lack health insurance. In addition, SAMHSA (2014) reported that nationwide, about one in five gay and bisexual men and one in four lesbian and bisexual women are living in poverty and more than 25 % of transgender Americans report an annual household income of less than $20,000.

Creating a safe and welcoming clinical environment is essential to break down barriers that may prevent older LGBT clients from accessing mental health services. A welcoming environment creates an atmosphere where people feel safe and cared for as individuals. A safe and welcoming clinical environment would provide a nonjudgmental, safe space that includes messages of inclusiveness such as a non-discrimination policies, culturally competent intake forms, appropriate educational materials, and courteous and respectful staff. It would also require that providers and their staff be culturally competent and sensitive and willing to engage the individual "where they are at." Cultural sensitivity includes valuing and respecting diversity and being sensitive to cultural differences. Another feature of a safe and welcoming clinical environment includes the ability of the client to be able to engage in open and honest communication with their provider. This is essential to the development of an effective therapeutic relationship. Therefore, effective communication must be stressed on the part of both the provider and the client.

Confidentiality, quality of services, and ethical behavior are all important factors when seeking mental health care and treatment. Historically, many minority communities have been subject to an array of unethical and unprofessional behaviors as a result of the structure of the healthcare system. For the LGBT community, concerns regarding homophobia, transphobia, and discrimination may keep LGBT elders from seeking services as they often assume that they will not be welcomed. In a study by Browne et al. (2008), several departments within a hospital system were identified that would particularly benefit from increased LGBT sensitivity training including chronic disease (including cancer and diabetes) and long-term care, and mental health. Gaining understanding of the culture of institutions with a history of discrimination and insensitivity to minority populations is essential for the development of effective intervention strategies.

At present, there are only a few LGBT inclusive aging providers in the USA who provide specialized services to the LGBT community. These organizations acknowledge and understand the concern of LGBT elders and the requirement for sensitivity and respect. Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE) is one such organization. SAGE is dedicated to improving the lives of LGBT older adults by targeting services specifically to LGBT older adults.

Counselor Competency

Counselor competency specific to LGBT older adults requires understanding of the sexual minority experience, the aging experience, and the effect that those experiences have had on the life of an LGBT elder. The importance of training for therapists to improve culturally competent practice with LGBT clients is well noted in the literature (King and McKeown 2004; Mair 2003). Mental health therapists require an understanding of how the psychological development of growing up LGBT differs from mainstream heterosexual development. Core training on LGBT development and lifestyle is central to recognize

and avoid heteronormative bias, to gain awareness of internalized bias in the LGBT client, to gain awareness of personal attitudes that could impact the therapeutic relationship, and to consider the advantages and disadvantages of self-disclosure of sexual orientation and identity (King et al. 2007). Conversion or reparative therapy describes a range of psychological treatments that aim to change sexual orientation from homosexual to heterosexual. As a culturally competent practitioner, it is essential to understand the impact of conversion therapy in terms of its anti-gay impact on the individual and on society. Research has demonstrated that attempts by mental health professionals to pathologize and treat or change sexual orientation are unwelcome and lead to dissatisfactions and lower perceived helpfulness of therapy (King et al. 2007).

Counselor competency is especially critical for LGBT older adults receiving mental health services from majority group members (i.e., heterosexual service providers). The long-term effect of living in a minority status leaves the LGBT elder with more vulnerability to experiencing low self-esteem and internalized homophobia. The counselor must acknowledge the synergy of the two minority statuses (age and LGBT) and assist the client in creating positive self-esteem that defies the negative messages from society.

Counselor competency in LGBT elder issues requires that the counselor be sensitive to the following:

- The social and historical context presented by the client

  The counselor must be cognizant of how LGBT elders have been affected by the physical and social setting of a society where the cultural normative was heterosexuality and where LGBT elders were identified as the "Other" (e.g., different and separated from the norm). The historical context (i.e., politics, culture, religion, economics, mood, and attitudes) of the time played a dominant role in the individual development of the LGBT elder both positively and negatively.

- The language utilized by the client specific to their historical context

  The counselor must be conscious of the language and the meanings conveyed by language associated with the societal and cultural environment. The language utilized by the LGBT elder should be seen as indicative of their perception of the larger society.

- Ageism, fear of aging, homophobia, and transphobia (i.e., attitudes and prejudices within the larger society and within the LGBT community)

  Counselor education regarding the effects of ageism, fear of aging, homophobia, and transphobia is essential to counselor competency. The counselor's ability to relate to, empathize with, and assist the LGBT elder in the navigation of systems that are negatively affecting the individual is an imperative.

- Empathy and compassion regarding the LGBT/minority experience

  The counselor's ability to comprehend and show compassion of the minority experience will have a profound effect on the professional relationship. What does the minority experience specific to sexual orientation and gender mean to the individual's self-identity? How does this particular minority experience influence the LGBT elder's relationship with others and with himself? What are the other minority experiences of the LGBT elder and how have they affected the individual's development?

- Understanding of the intersectionality between LGBT issues, race, ethnicity, and aging

  The counselor's ability to understand the intersectionality of LGBT issues, race, ethnicity, and aging is critical to a holistic perception of the LGBT elder. What have been the experiences of the LGBT elder because of their sexual orientation, gender, race, ethnicity, and aging? Have these factors intersected, collided, or both? All of the factors identified have presented the

LGBT elder with both positive and negative experiences.

- Provision of an inclusive environment
  Providing an inclusive environment is central to building trust within the counselor/client relationship. An inclusive and welcoming environment includes honesty, flexibility, recognizing and valuing differences, open dialogue, and respectful interactions.

The implications of empirical data on this topic suggest that the mental health system must do more than sensitize counselors to the issues that face LGBT older adults. It is critical to provide education and training to create culturally competent providers skilled at person-centered care. Counselor competency specific to LGBT older adults must incorporate an understanding of the stigma, discrimination, and long-term effects of the sexual minority experience coupled with the aging experience for LGBT people in a society where youth is valued and the aging process is often misunderstood.

Counselor competency with the LGBT community, and specifically LGBT older adults, requires ongoing training and translation. The goal of training is far greater than simply sensitizing counselors to issues that LGBT older adults face; training must include the voices of the LGBT community through face-to-face interaction in order to gain deeper insight and understanding of an LGBT individual. Counselor competency for LGBT elders and the larger LGBT community requires that the mental health system seeks out LGBT professionals with the intent to collaborate with, refer clients to, and dialogue about LGBT issues that benefit both clients and the larger community. It is imperative that counselors receive appropriate training regarding the LGBT culture and lifestyle and that there is honesty and empathy in their understanding of the long-term effects of living a minority status in mainstream society. Ultimately, competent counseling requires the provision of a safe and trusting environment. Therefore, a competent counselor will strive to provide a person-centered approach to care by creating a safe and nonjudgmental therapeutic environment that encourages honesty and self-acceptance.

Discussion Box 3

Is it important to know about the sexual orientation of an older adult client seeking mental health services? Why or why not?

In general, do you think LGBT individuals age well? Why or why not? What risk factors or protective factors do you think are important?

Discussion Box 4

In your own words, define counselor competency **specific to the needs** of LGBT older adults.

What does your definition of counselor competency include? Is your definition inclusive?

Profile

Ms. G and Ms. B are 70-year-old lesbians who have been in a loving committed relationship for 37 years. The couple was married in 2008 in California. Both Ms. G and Ms. B report that when they came out 40 years ago, neither of their parents was happy. Ms. G's parents made attempts to get Ms. G's ex-husband to secure sole custody of their children due to their homophobic attitudes and fear that their grandchildren would have emotional scars. However, he would not, and instead, they shared custody of their children. At age 70, Ms. G is a practicing mental health therapist and counsels LGBT clients. "During my training, we focused strongly on understanding the dynamics unique to the lives of minority clients including women, LGBTQ, and people of color." Question for discussion: What elements of Ms. G and Ms. B's lives support their optimal aging?

Critical Research to Mental Health Issues of LGBT Elders

Although very few empirical studies have been conducted on mental health of the aging LGBT population, studies that do exist have demonstrated high life satisfaction and positive attributes to aging as an LGBT individual (Berger 1992). A study conducted by D'Augelli et al. (2001) found that mental health in older adulthood was influenced by better physical health, better cognitive functioning, higher self-esteem, less loneliness, and a higher percentage of people knowing about the individual's sexual orientation. In addition, suicidal ideation was predicted by negative feelings about one's sexual orientation, loneliness, and few people knowing about the individuals' sexual orientation. D'Augelli et al. 2001 found that vast majority of LGBT older adults in their sample reported good-to-excellent mental health and unchanged or improved mental health over the past five years. Mental health was positively related to income, indicating better mental health for those with higher income, and was negatively correlated with victimization, indicating that people who reported more victimization had lower levels of mental health. D'Augelli and Grossman (2001) looked at how disclosure of sexual orientation and victimization related to mental health in a sample of LGBT older adults aged 60 and older. Study results indicated that almost three-quarters of participants reported some form of victimization (verbal and/or physical). Poor mental health, as indicated by lower self-esteem, more loneliness, and more suicide attempts were reported by those that had been physically attacked (D'Augelli and Grossman 2001).

Studies have demonstrated that the prevalence of mood and anxiety disorders, substance abuse, and suicide attempts is higher among LGBT individuals than among heterosexuals (Cochran et al. 2003; Lytle et al. 2014). A meta-analysis by King et al. (2007) found that sexual minority individuals have a 1.5 times higher risk for depression and anxiety disorders and are 2.5 times more likely to attempt suicide than heterosexuals. Cochran et al. (2003) found that the prevalence of panic attacks was greater in gay or bisexual men than in heterosexual men and that lesbian or bisexual women had a significantly greater 12-month prevalence of GADs.

A study by Lombardi (2009) found that older transgender people reported more stress as a result of lifetime experiences of discrimination. Study results found that post-transition, older people reported more discrimination and stress, which continues as a constant experience for people even after they transition (Lombardi 2009).

Related Disciplines Influencing Service Delivery and Interdisciplinary Approaches

LGBT older adults will seek services from an interdisciplinary team of professionals as they age within their communities. This cadre of professionals will include gerontologists, social workers, psychologists, geropsychologists, administrators, and healthcare and allied healthcare professionals.

The National Association of Social Workers (NASW) states, as one of its dual missions, to "seek to enhance the effective functioning and well-being of individuals, families, and communities through its work and through its advocacy." Social workers assist individuals, families, and communities in their attempt to reach their full potential through a myriad of services. Working in a variety of fields, social workers provide services in schools, churches, hospitals, police departments, prisons, community mental health clinics, psychiatric hospitals, not-for-profit and for-profit organizations, retirement communities, nursing homes, substance abuse clinics, court systems, and in other arenas. In the provision of social work services to LGBT elders, social workers are integral in assisting LGBT elders to find their voice and advocate for themselves. Social workers can and do provide avenues for interdisciplinary service involvement through their participation in many different fields in the community. For example, a medical social

worker providing case management services in the home of a client will have a better understanding regarding the struggles the older adult is having that is limiting his ability to take his medications. The social worker would be able to share with the medical team the client's issues, and an action plan would be put in place to decrease and/or eliminate concerns. Also, in the provision of services to LGBT elders, social workers offer support, advocacy, and a voice. Acting as a bridge and a support system, social workers engage other disciplines on behalf of the LGBT elder seeking services. The discipline of social work influences service delivery positively through the utilization of a holistic and strength perspective offering nonjudgmental interventions.

As a discipline, psychology studies the behavior of humans and how their minds work in order to improve human behavior. Psychologists and geropsychologists deliver mental health counseling, as well as administer psychological evaluations, testing, and diagnosis. A psychologist or geropsychologist can work with older adults to cognitive and mood assessments and individual and group counseling. The American Psychological Association (APA) has demonstrated a commitment to research and education to support LGBT mental health and has established a division (Div 44) for the psychological study of LGBT issues.

An interdisciplinary approach to service delivery for the LGBT aging community is essential to the provision of culturally competent care. Aside from mental health professionals, medical and allied health professionals will require education and training on specific issues relevant to aging as an LGBT individual. Medical and allied health professionals are often the first stop in the care continuum and are responsible for providing appropriate services and/or referrals to meet the needs of their clients. In order to break down the barriers to seeking mental health services, an interdisciplinary approach to service provision will be necessary to ensure quality mental health care for LGBT older adults.

Summary

Culturally competent practice is essential to address the mental health needs of the aging LGBT community. A culturally competent practitioner must have awareness of issues that specifically impact sexual minority clients along with topics that are relevant specifically to older adults. Practitioners must be aware of the diversity of cultures in which LGBT older adults developed in order to comprehensively address current mental health needs. In other words, both the potential risk factors and protective factors experienced over the course of the life span must be examined as a part of a holistic therapeutic plan for an LGBT older adult.

In addressing the mental health needs of LGBT older adults, it is essential to take a person-centered approach to care and service provision. Person-centeredness recognizes the uniqueness of each person and empowers the individual to be the driver of her own care. Becoming a culturally competent mental health provider requires taking a person-centered approach by recognizing that meeting one older person is meeting ONE older person. Culturally competent service providers and practitioners are aware of generalizations based on age, sexual orientation, and/or gender identity. Culturally competent service providers and practitioners take into account the unique history and life experiences of each individual and her life journey to provide holistic person-centered care.

Learning Exercises for Knowledge Gain

1. According to minority stress theory, LGBT individuals face disparities in health outcomes, which are explained by stressors induced by discrimination and victimization (Meyer 2003). How does minority stress theory specifically relate to an LGBT older adult? How does minority stress theory relate

to LGBT older adults seeking mental health services?
2. Identify 5 barriers for LGBT older adults that may prevent them from accessing mental health services.
3. Describe 5 essential components of culturally competent training for mental health providers working with older LGBT clients.
4. Why is body image and eating particularly prevalent among gay men? How does the view of aging within the LGBT community impact body image and eating disorders?

Multiple-Choice Questions

1. Which of the following is a cause of depression and anxiety in LGBT elders?
   (a) Low self-esteem
   (b) Isolation
   (c) Denial of true self
   (d) All of the above
2. George is a 75-year-old gay man who never came out with his family and friends. Which of the following would he likely be at an increased risk for?
   (a) GAD
   (b) Higher blood pressure
   (c) High cholesterol
   (d) A personality disorder
3. A welcoming environment would include all of the following except
   (a) An inclusive gender section (i.e., male, female, transgender)
   (b) A non-discriminatory policy
   (c) Male- and female-only restrooms
   (d) Courteous, respectful staff
4. Which of the following is a barrier to service utilization?
   (a) Open and honest communication
   (b) Fear of discrimination
   (c) Professional's knowledge of the LGBT community
   (d) Nonjudgmental, safe space that includes messages of inclusiveness
5. Which of the following is true regarding counselor competency?
   (a) It requires understanding of the sexual minority experience
   (b) Becoming a culturally competent mental health provider requires taking a psychoanalytic approach
   (c) Training and education on LGBT aging issues is important for promoting counselor competency
   (d) Both A & C
6. Counselor competency in LGBT elder issues requires that the counselor understands
   (a) Social and historical context presented by the client
   (b) Knowledge of the client's views on fashion
   (c) Understanding of the intersectionality between LGBT issues, race, ethnicity, and aging.
   (d) Both A & D
7. Transphobia is
   (a) A lack of understanding of the psychology of the transgender individual
   (b) A feeling of unease toward those who identify as transgender
   (c) A clinical terminology no longer used to describe men who dress as women
   (d) The fear of people who are bisexual
8. Transgender individuals often experience discrimination in the form of
   (a) Employment discrimination
   (b) Physical abuse
   (c) Verbal harassment
   (d) All of the above
9. What are the factors that can negatively impact the mental health of LGBT older adults?
   (a) Self-imposed or societal isolation
   (b) A pattern of out-of-control sexual behavior
   (c) Ageism
   (d) Both A & C
10. Research has demonstrated that good mental health outcomes were indicated for LGBT individuals
   (a) Who had lifetime partners
   (b) Had an active religious affiliation
   (c) Who were out about their sexual orientation or gender identify
   (d) Both A & C

Key

1. (D)
2. (A)
3. (C)
4. (B)
5. (D)
6. (D)
7. (B)
8. (D)
9. (D)
10. (C)

Field-Based Experiential Assignments

1. Interview a mental health practitioner that specializes in working with LGBT clients. What did you learn about addressing the psychological/mental health needs of LGBT elders? What advice were you given about how to be a culturally competent provider?
2. Attend training on a mental health topic for LGBT older adults. The training can be facilitated by a local LGBT organization or a national LGBT organization such as Services and Advocacy with Gay, Lesbian, Bisexual and Transgender Elders (SAGE) or another institute providing education and training to the community.
3. Volunteer with the local LGBT Community Center in your area to become more familiar with LGBT community needs and resources and specifically to investigate the community needs of the aging LGBT population.

Resources

1. National Alliance on Mental Illness. http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Resources/GLBT_Resources.htm
2. LGBT Aging Resources Issues Clearinghouse (part of the American Society on Aging) http://asaging.org/lgbt_aging_resources_clearinghouse
3. National Resource Center on LGBT aging http://www.lgbtagingcenter.org/
4. The Pride Institute http://pride-institute.com/
5. National LGBT Health Education Center at the Fenway Institute www.lgbthealtheducation.org
6. Project HEALTH—A program of Lyon-Martin Health Services and the Transgender Law Center www.project-health.org
7. SAMHSA Top Health Issues for LGBT Populations Information and Resource Toolkit http://store.samhsa.gov/product/Top-Health-Issues-for-LGBT-Populations/SMA12-4684.

References

Aneshensel, C. S. (1992). Social stress: Theory and research. *Annual review of sociology, 18*(1), 15–38.

Barranti, C., & Cohen, H. (2000). Lesbian and gay elders: An invisible minority. In R. Schneider, N. Kropt, & A. Kisor (Eds.), *Gerontological social work: Knowledge, service setting, and special populations* (2nd ed., pp. 343–367). Belmont, CA: Wadsworth.

Beekman, A. T., Copeland, J. R., & Prince, M. J. (1999). Review of community prevalence of depression in later life. *British Journal of Psychiatry, 174*, 307–311.

Berger, R. M. (1992). Research on older gay men: What we know, what we need to know. In J. J. Woodman (Ed.), *Lesbian and gay lifestyles: A guide for counseling and education* (pp. 217–234). New York: Irvington.

Blazer, D. G., & Hybels, C. F. (2005). Origins of depression in later life. *Psychological Medicine, 35*, 1241–1252.

Bockting, W. O., Knudson, G., & Goldberg, J. M. (2006). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism, 9*(3–4), 35–82.

Browne, D., Woltman, M., Tumarkin, L., Dyer, S., & Buchbinder, S. (2008). Improving lesbian, gay, bisexual and transgender access to healthcare at New York City health and hospitals corporation facilities.

Clements, K. (1999). *The transgender community health project: Descriptive results*. San Francisco: San Francisco Department of Public Health.

Clements-Noelle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health*, *91*, 915.

Cochran, S. D., & Mays, V. M. (2000). Lifetime prevalence of suicide symptoms and affective disorders among men reporting same-sex sexual partners: Results from NHANES III. *American Journal of Public Health, 90*(4), 573.

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71*(1), 53.

D'Augelli, A. R., & Grossman, A. H. (2001). Disclosure of sexual orientation, victimization, and mental health among lesbian, gay, and bisexual older adults. *Journal of Interpersonal Violence, 16*(10), 1008–1027.

D'Augelli, A. R., Grossman, A. H., Hershberger, S. L., & O'Connell, T. S. (2001). Aspects of mental health among older lesbian, gay, and bisexual adults. *Aging and Mental Health, 5, 149.*

Davenport -Hines, R. (1990). *Sex, death and punishment: Attitudes to sex and sexuality in Britain since the Renaissance*. London: Collins.

Dohrenwend, B. P. (2000). The role of adversity and stress in psychopathology: Some evidence and its implications for theory and research. *Journal of health and social behavior*, 1–19.

Feldman, M. B., & Meyer, I. H. (2007). Eating disorders in diverse lesbian, gay, and bisexual populations. *International Journal of Eating Disorders, 40*(3), 218–226.

Fredriksen-Goldsen, K. I., & Muraco, A. (2010). Aging and sexual orientation: A 25-year review of the literature. *Research on Aging, 32*(3), 372–413.

French, S. A., Story, M., Remafedi, G., Resnick, M. D., & Blum, R. W. (1996). Sexual orientation and prevalence of body dissatisfaction and eating disordered behaviors: A population-based study of adolescents. *International Journal of Eating Disorders, 19*, 119–126.

Gabbay, S. G., & Wahler, J. J. (2002). Lesbian aging: Review of a growing literature. *Journal of Gay & Lesbian Social Services, 14*(3), 1–21.

Glacken, M., & Higgens, A. (2008). The grief experience of same sex couples within an Irish context: Tacit acknowledgement. *International Journal of Palliative Nursing, 14*, 297–302.

Herek, G. M., & Garnets, L. D. (2007). Sexual orientation and mental health. *Annual Review of Clinical Psychology, 3*, 353–375.

Herzog, D. B., Newman, K. L., & Warshaw, M. (1991). Body image dissatisfaction in homosexual and heterosexual males. *Journal of Nervous and Mental Disease, 179*, 356–359.

Hill, D. B. (2002). *Genderism, transphobia, and gender bashing: A framework for interpreting anti-transgender violence*. Thousand Oaks, CA: Sage.

Hybels, C. F., & Blazer, D. G. (2003). Epidemiology of late-life mental disorders. *Clinics in Geriatric Medicine, 19*(4), 663–696.

Jacobson, S., & Grossman, A. H. (1996). Older lesbians and gay men: Old myths, new images, and future directions. *The lives of lesbians, gays, and bisexuals: Children to adults*, pp. 345–373.

Jorm, A. F. (2000). Does old age reduce the risk of anxiety and depression? A review of epidemiological studies across the adult life span. *Psychological Medicine, 30*, 11–22.

Kimmel, D. (1978). Adult development and aging: A gay perspective. *Journal of Social Issues, 34*, 113–130.

King, M., McKeown, E. (2004). Gay and lesbian identities and mental health. In D. Kelleher & G. Leavey (Eds.), *Identity and Health*. London: Routledge.

King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2007). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry, 8*(1), 70.

Lakkis, J., Ricciardelli, L. A., & Williams, R. J. (1999). The role of sexual orientation and gender related-traits in disordered eating. *Sex Roles, 41*(1–2), 1–16.

Lewis, D. M., & Cachelin, F. M. (2001). Body image, body dissatisfaction, and eating attitudes in midlife and elderly women. *Eating Disorders, 9,* 29–39.

Lombardi, E. (2001). Enhancing transgender health care. *American Journal of Public Health, 91*(6), 869–872.

Lombardi, E. (2009). Varieties of transgender/transsexual lives and their relationships with transphobia. *Journal of Homosexuality, 56*, 977–992.

Lytle, M. C., Luca, S. M., & Blosnich, J. R. (2014). The influence of intersecting identities on self-harm, suicidal behaviors, and depression among lesbian, gay, and bisexual individuals. *Suicide and Life-Threatening Behavior*, *44,* 384.

Mackenzie, C. S., Reynolds, K., Chou, K. L., Pagura, J., & Sareen, J. (2011). Prevalence and correlates of generalized anxiety disorder in a national sample of older adults. *The American Journal of Geriatric Psychiatry, 19*(4), 305–315.

Mair, D. (2003). Gay men's experiences of therapy. *Counseling and Psychotherapy Research Journal, 3*, 33–41.

Makadon, H., Mayer, K., Potter, J., & Goldhammer, H. (2008). The Fenway guide to gay, lesbian, bisexual and transgender health.

Mays, V. M., & Cochran, S. D. (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health, 91*(11), 1869–1876.

McIntyre, J., Daley, A., Rutherford, K., & Ross, L. E. (2011). Systems level barriers in accessing supportive mental health services for sexual and gender minorities: Insights from the provider's perspective. *Canadian Journal of Community Mental Health, 30*(2), 173–186.

Meyer, C., Blissett, J., & Oldfield, C. (2001). Sexual orientation and eating psychopathology: The role of masculinity and femininity. *International Journal of Eating Disorders, 29*(3), 314–318.

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36* (1), 38–56.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674.

Meyer, I. H. (2007). Prejudice and discrimination as social stressors. In *The health of sexual minorities* (pp. 242–267). Springer US.

Murnen, S. K., & Smolak, L. (1997). Femininity, masculinity, and disordered eating: A meta-analytic review. *International Journal of Eating Disorders, 22*, 231–242.

National Alliance on Mental Illness. (n.d.). Retrieved August 18, 2014, from http://www.nami.org/Template.cfm?Section=Depression&Template=/ContentManagement/ContentDisplay.cfm&ContentID=144036.

National Institute on Mental Illness (2014). State Mental Health Legislation 2014: Trends, Themes & Effective Practices. NAMI.

Orel, N. A. (2004). Gay, lesbian, and bisexual elders: Expressed needs and concerns across focus groups. *Journal of Gerontological Social Work, 43*(2/3), 57–75.

Pritchard, M. (2008). Disordered eating in undergraduates: Does gender role orientation influence men and women the same way? *Sex Roles, 59*(3–4), 282–289.

Rado, S. (1949). A adaptational view of sexual behavior. In P. H. Hoch & J. Zubin (Eds.), *Psychosexual Development in Health and Disease*. New York: Grune & Statton.

Reback, C. J., Simon, P. A., Bemis, C. C., & Gatson, B. (2001). *The Los Angeles transgender health study: Community report*. Los Angeles: University of California at Los Angeles.

Rubin, R. H. (2001). Alternative lifestyles revisited, or whatever happened to swingers, group marriages, and communes? *Journal of Family Issues, 22*(6), 711–726.

Schope, R. D. (2005). Who's afraid of growing old? Gay and lesbian perceptions of aging. *Journal of Gerontological Social Work, 45*(4), 23–39.

Siever, M. D. (1994). Sexual orientation and gender as factors in socioculturally acquired vulnerability to body dissatisfaction and eating disorders. *Journal of Consulting and Clinical Psychology, 62*(2), 252.

Smith, G., Bartlett, A., & King, M. (2004). Treatments of homosexuality in Britain since the 1950s—an oral history: The experience of patients. *BMJ, 328*(7437), 427.

Striegel-Moore, R. H., Tucker, N., & Hsu, J. (1990). Body image dissatisfaction and disordered eating in lesbian college students. *International Journal of Eating Disorders, 9*(5), 493–500.

Strong, S. M., Williamson, D. A., Netemeyer, R. G., & Geer, J. H. (2000). Eating disorder symptoms and concerns about body differ as a function of gender and sexual orientation. *Journal of Social and Clinical Psychology, 19*(2), 240–255.

Substance Abuse and Mental Health Services Administration. (2014). Affordable care act enrollment assistance for LGBT communities, a resource for behavioral health providers. Rockville, MD, substance abuse and mental health services administration.

The Aging and Health Report Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults. (2010). Retrieved August 18, 2014, from, http://caringandaging.org/wordpress/wp-content/uploads/2012/10/Full-report10-25-12.pdf.

Webster, J., & Tiggemann, M. (2003). The relationship between women's body satisfaction and self-image across the life span: The role of cognitive control. *The Journal of Genetic Psychology, 164*(2), 241–252.

Wichstrom, L. (2006). Sexual orientation as a risk factor for bulimic symptoms. *International Journal of Eating Disorders, 39*(6), 448–453.

Williamson, I., & Hartley, P. (1998). British research into the increased vulnerability of young gay men to eating disturbance and body dissatisfaction. *European Eating Disorders Review, 6*, 160–170.

Yager, J. (2000). Weighty perspectives: Contemporary challenges in obesity and eating disorders. *American Journal of Psychiatry, 157*(6), 851–853.