# Theories, Constructs, and Applications in Working with LGBT Elders in Human Services

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**Abstract**

This chapter presents an overview of select theories of sexual orientation and gender identity. Traditional theories of life span development offer a general framework within which to understand issues and experiences common to persons in later stages of life. The intent of this chapter is to discuss theoretical constructs and models of sexual identity, counseling, public health, gerontology, and social work that can be applied with aging LGBT populations. These theories underscore the necessity of helping present and future professionals who understand differences among LGBT elders and the complex nature of identity, their psychosocial adjustment, and ways in which stigma of sexual identity and gender identity affects their well-being. Although the various theories and models in this chapter are presented according to discipline, theories are not mutually exclusive to disciplines.

**Keywords**

LGBT theories · Sexual orientation identity development · Gender identity development · Life span development theories

## Overview

This introductory chapter on theories, constructs, and applications in working with LGBT elders presents an overview of select theories of sexual orientation and gender identity. The reader is reminded that just as identities are culturally defined, theories of sexual identity are framed within cultural contexts as well. Thus, the terminology of the "LGBT" acronym may not accurately reflect how sexual minorities are discussed within certain cultures. However, Burleson (2005) nevertheless points out that "the sexual identity of bisexual, heterosexual, or homosexual is cultural; feelings of attraction are organic. People are hammered into molds, albeit their own culture's mold, the world over" (p. 37). Most of the models of sexual orientation and

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gender identity are based on Eurocentric cultural models of sexuality. Traditional theories of life span development (e.g., Erikson 1950; Levinson 1978, 1996) offer general frameworks within which to understand issues and experiences common to persons in later stages of life (Hash and Rogers 2013).

Although it is beyond the scope of this chapter to include all theories, constructs, and applications in human services, our intent is to present an overview of select theoretical constructs and models of sexual identity, counseling, public health, gerontology, and social work that can be applied with aging LGBT populations. These theories underscore the necessity of helping present and future professionals who understand differences among LGBT elders and the complex nature of identity, their psychosocial adjustment, and ways in which the stigma of sexual identity and gender identity affects their well-being. Specific theories of late adulthood development and functional capacity are presented in Chap. 3. Also, it is not the intent of this chapter to present techniques for counseling LGBT elder in specific circumstances (e.g., couples or relationship, family, mental), nor to critique various theories. Although the various theories and models in this chapter are presented according to discipline, theories are not mutually exclusive to disciplines. A theory may easily be applied by various disciplines to investigate and explain behavior and phenomenon.

## Learning Objectives

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

1. Understand the various theories of LGBT identity development.
2. Identify the counseling theories that can be applied effectively for work with LGBT elders.
3. Identify the theories of public health and practice.
4. Identify the social work theories that work effectively with LGBT elders.
5. Explain how various practice models can be integrated in working with LGBT elders.

## Introduction

Theory is a general statement, proposition, or hypothesis about a real situation that can be supported by evidence obtained through a scientific method. A theory explains in a proven way why something happens and offers guidance in explaining and responding to forgoing problems (Gratwick et al. 2014). A construct is an idea, often referred to as a theory, which contains conceptual elements or parts that are put together in a logical order to explain something. Constructs are typically subjective and not based on empirical evidence. A model is a blueprint for implementation. It describes what happens in practice in a general way. Theory and models are influenced by perspective, a value position (Payne 1997). Every discipline has theories to explain particular phenomena upon which it operate to guide development of hypotheses, research, and recommendations for best practices and policy. In fact, Payne suggests that theory succeeds best when it contains all three elements —perspective, theory, and model/construct. Theory serves the function of providing practitioners a guide for behavior in very specific circumstances and making decisions.

Although various disciplines study aging, the study of older persons occurs primarily within the discipline of gerontology. Hooyman and Kiyak (2008) suggest that because of the multidisciplinary nature of gerontology, examination of aging on the societal, psychosocial, and biological levels. However, on all these levels, older sexual minorities (lesbian, gay, bisexual, transgender [LBGT]) have been relatively ignored in gerontological research (Grossman 2008; Orel 2004; Quam 2004). Similarly, very little content

on specific care needs of LGBT persons exists in the nursing literature, especially for older adults. This lack of focus is particularly troubling because nurses and other such caregivers are the front line of care and are in a position to create health care environments that will meet the needs of LGBT elders (Jablonski et al. 2013). In addition, many other disciplines omit LGBT populations from curricula and research to the extent that it appears that sexual minorities do not even exist (Hall and Fine 2005; Harley et al. 2014). The lack of focus on LGBT elders in research and training programs frequently results in service providers who are inadequately to meet the needs of this population. According to Gratwick et al. (2014), "even when providers of aging services express willingness to become more responsive to the needs of LGBT older adults there is evidence that they do not take sufficient action" (p. 5). Hughes et al. (2011) report that of service providers affiliated with the National Association of Area Agencies on Aging, only 15 % provide services tailored to the need of older LGBT adults. Moreover, at the organizational level, LGBT older adults are literally not being seen, organizations are not directing resources to these populations, and it appears that there is agency resistance to acknowledging the distinctiveness of LGBT aging issues.

Considering the increase in the number of older persons in general and the projection for continued growth in numbers and anticipated growth in the one to three million individuals in the USA over age 65 who are already identified as LGBT, the lack of focus of multidisciplinary research relegates older LGBT persons to a status of invisibility. Mabey (2011) contends that the omission of LGBT elders in gerontological research "leaves professional counselors without a substantive bridge with which to connect resources with treatment planning when working with sexual minorities" (p. 57). Moreover, ageism as experienced in LGBT communities has the additional impact of making a marginalized and stigmatized group feel even more of a minority.

## Elderly LGBT Diversity, Identity, and Resilience

As an LGBT person and an older person, an LGBT elder does not belong to one homogenous group within the acronym. LGBT elders come from every race and ethnicity, nationality, gender, ability level, socioeconomic status, place, and space. Some LGBT elders have been married and have children, while other have either or neither. Thus, LGBT elders cannot be grouped or treated as one cohesive category (Mabey 2011). Older LGBT persons grew up during a time when homosexuality and gender nonconformity were viewed as a mental illness, a sin, or a sexual perversion. Open discussion about homosexuality, sexual identity, and gender identity was not done. Rather, secrecy about one's sexual desires and behaviors was the norm; to reveal that one's sexual orientation was other than heterosexual or one's gender identity was other than conforming to social expectations was not only vocationally and socially devastating, but patently unsafe. Negative attitudes and perceptions about LGBT persons are not only historical. Today, heterosexism, homophobia, transphobia, and biphobia continue to be intertwined in social customs, cultural beliefs, institutional structures, and policy development. It is both the long-term and ongoing socially sanctioned discrimination, prejudice, and stereotypes that present unique challenges and, ironically, opportunities for LGBT persons globally (e.g., Austria, Canada, England, Ireland, USA). Because of the diversity among LGBT elders, some of the stereotypes encompass the entire LGBT population such as its attempts to covert heterosexuals that the population is composed of pedophiles or that it is a threat to marriage and structure of the family. Other

stereotypes are specific to subgroups of LGBT persons such as the belief that a lesbian cannot "get a man," gay men are responsible for HIV/AIDS, or that older LGBT persons are not attractive.

In a society that places an inordinate emphasis on youth, older adults face stigma and discrimination beyond that of their younger counterparts, especially ageism (Butler 1994) in addition to lifelong negative attitudes and poor treatment related to their sexual orientation and gender identity. Hash and Rogers (2013) acknowledge "while these difficult experiences can create a host of problems for LGBT individuals, they can also help them develop unique skill sets or strengths that their non-LGBT counterparts do not necessarily benefit from as they age" (p. 249). Further, Hash and Rogers suggest that despite difficulties associated with aging as LGBT persons, elders have successfully developed social networks, successfully developed a strong sense of identity through the coming-out process, and have successfully responded to discrimination and stigma to develop a positive sense of self and identity leading to stronger ego integrity. Despite the challenging and threatening context often associated with LGBT elders' earlier lives, most are now comfortable with their sexual orientation and gender identity and display a marked resilience to the minority stress they experienced in their lives (Irish Association of Social Workers 2011; Szymanski and Gupta 2009) (see especially Chaps. 6, 7, 8 and 10 in this book on resilience among LGBT elders of color).

The process of aging for LGBT persons presents the typical challenges and concerns related to health status, financial stability, loss of a spouse or partner, and so forth. We present the case of Maria, a Latina 73-year-old lesbian, to illustrate some of the challenges she faces.

As a member of the Latino culture Maria believes that the Latino community is less accepting of homosexuality. Maria recognizes that living in Los Angeles she faces the challenges of being invisible because of ageism, an LGBT community that values youth, and rejection of old persons. In addition, cultural barriers and being very self-reliant further isolate Latinos LGBT elders. In a needs assessment of older Hispanic LGBT adults, participants expressed varied experiences of aging as: (a) not different from that of the general population, with more self-acceptance, particularly if one is financially secure, (b) there is a great deal of rejection of older persons because they are persons in which people are not interested and, even why they do not have a support group even among themselves, (c) social isolation within their own families because of their identities as LGBT people, and (d) dual discrimination as Latinos and as members of the LGBT community (www.gallup/poll/158066/special-report-adults-identity-lgbt.aspx).

**Case of Maria**

Maria is a Latina 73-year-old lesbian. She and her partner of 40 years live in a small third floor apartment in Los Angles. The building is old and does not have an elevator. Maria has arthritis in her knees and hands, hypertension, and glaucoma. Here partner, Sophia, is in better health but has asthma. Neither Maria nor Sophia has children and both have been estranged from their families for most of their adult life. They consider themselves "closeted" and have identified themselves publically as sisters.

Maria worked for 55 years as a housekeeper for a wealthy family. She does not have retirement income and receives Social Security of $540 per month, Medicare, and food stamps. Sophia worked as a city bus driver for 30 years and receives retirement benefits, Social Security, and Medicare.

The two of them are concerned about the feasibility of continuing to live in their apartment, but know that it will be difficult to find other affordable housing. In addition, their share of cost for health care continues to increase. Although neither women have been diagnosed with depression, both express having feelings of depression.

**Questions**

What identity issues are confronting these two women?
Do they have a social network? How can they form a social network?
Can you identify resilience factors for Maria and Sophia?
What type of service would benefit Maria and Sophia?

As previously mentioned, the theories of Erikson (1950) and Levinson (1978, 1996) have foundational significance in explaining the psychological development of LGBT elders. In Erikson's final stage of psychosocial development, *Ego Integrity v. Despair*, older adults (age 60 and over) reflect upon and evaluate their lives. When confronted with loss, the older person must arrive at acceptance of his or her life or will fall into despair. The ability to accept one's life and self in the ego integrity stage may be more complicated for LGBT elders (Hash and Rogers 2013; Humphreys and Quam 1998). According to Humphreys and Quam, the social stigma experienced by LGBT elders can adversely affect how they view their identity and life. Despair can be influenced by the culmination of losses over a lifetime. Transgender persons may be at a greater risk for despair because of the indignity they face from society and lack of support from loved ones. Moreover, older LGBT adults may have struggled with development as reflected in earlier stages of Erikson's theory, which could impact developmental tasks during the final stage. Levinson's theories of life span development examine primary pattern of people's lives at particular points in time and the transitions necessary between eras in life for them to successfully develop into adulthood. Similar to Erikson, Levinson identifies the final era as older adulthood (age 60 and over). This era often involves significant adjustment to a significant change and acceptance of immortality. For LGBT elders, this late stage life transition may involve acceptance and openness about sexual orientation and gender identity (Humphreys and Quam).

The remainder of this chapter concerns select theories and models used in the disciplines of counseling, public health, and selected social sciences. Sexual identity theories are also presented. As mentioned earlier, theories are not discipline specific; however, some disciplines may gravitate more toward certain theories and models.

## Theories and Constructs on Sexual Identity

An introduction to theories of sexual identity must at least mention the work of Sigmund Freud (1949). According to Freud, homosexuality and bisexuality resulted from unresolved conflicts (fixation) occurring within one of the stages of psychosexual development. In addition, Freud hypothesized that all human beings are innately bisexual and it is the influence of family and environment that determines if one becomes homosexual or heterosexual. However, Freud never identified homosexuality or bisexuality as a mental disorder. Freud's theory is not empirically tested and is not used today in discussion of sexual identity formation.

Later, the work of Erving Goffman (1963), *Stigma: Notes on the Management of Spoiled Identity*, was one of the most important early works addressing minority self-identity (Eliason and Schope 2007). According to Goffman, social stigma is learned and internalized through childhood socialization and shapes the minority person's identity. The minority person shares the belief of the majority if it deems that he or she is a failure and abnormal. This belief leads to self-hate and self-derogation. Goffman proposed that formation of the minority sexual identity involves dealing with social expectations of what is considered normal. Conversely, Altman (1971) and Plummer (1973) offered explanations for the development of a stable "homosexual identity" (Eliason and Schope 2007). Altman suggested

**Table 1.1** Plummer's stages of homosexual identity

| |
|---|
| Stage 1: Sensitization—thinks about one's sexual identity |
| Stage 2: Significance and disorientation—accepts the deviant label with all the potential social consequences. Social oppression creates disequilibrium where the homosexual person becomes stalled, perhaps for life, in this stage |
| Step 3: Coming-out—goes public with one's rebuilt sexual identity. Disclosure is linked to the person's willingness and ability to join the homosexual community |
| Stage 4: Stabilization—no longer questions one's homosexual identity |

Adapted from Plummer (1973)

that self-disclosure of one's homosexuality was beneficial because coming-out meant dealing with the socially learned "internalization of oppression," which is liberating. Plummer's approach was one of individuals adopting a "homosexual way of life" or a "career type" of sexuality. Recognizing homosexuality as a social construct developed by the majority to restrict and pathologize a sexual minority, Plummer argued that all forms of deviancy need to be viewed within a historical and cultural context. He regarded current social hostility to homosexuality as responsible for many of what he labeled "pathologies." Plummer was one of the first theorists to present identifiable stages of "homosexual identity" (see Table 1.1) (Eliason and Schope).

Subsequent to Altman (1971) and Plummer's (1973) theories, an abundance of stage models on sexual identity formation evolved, the majority of which moved away from the deviance model to a focus on healthy consequences of accepting one's sexuality (see Table 1.2). Eliason and Schope (2007) identify two assumptions about stage model theorists. First, most assumed that one is or is not gay or lesbian and embraced the argument from an Essentialists' perspective. Second, most models are based on a review of the literature and are not empirically tested or are based on single case or small sample size.

Probably, one of the most influential and frequently cited theories of gay and lesbian identity development is that of Cass (1979). Cass describes a process of six stages of gay and lesbian development. Although these stages are sequential, some persons revisit stages at different points in their life. Each stage is accompanied by a task. Cass believes that coming-out is a lifelong process of exploring one's sexual orientation and lesbian or gay identity and sharing it with others. Table 1.3 contains Cass's model of identity formation.

*Bisexual Identity Formation*. Though limited research as been conducted on development of bisexual identity formation, probably the most important research on bisexuality was that of Alfred Kinsey with the publication of *Sexual Behavior in the Human Male* (Kinsey et al. 1948) and *Sexual Behavior in the Human Female* (Kinsey et al. 1953) (as cited by Burleson 2005). Kinsey developed the Kinsey scale, in which individuals can fall anywhere along a continuum of 0 (exclusively heterosexual) and 6 (exclusively homosexual). Burleson contends that Kinsey had created the present model of bisexuality without ever once using the word bisexual. In addition, Kinsey scale clarified two issues: (a) There is great variability of sexual orientation, and (b) an implication that perhaps all human beings on this continuum are ranked the same way (i.e., heterosexuality is not primary or held above other sexual orientations). Kinsey's work, while groundbreaking, was rudimentary and did not address the complexities of behavior and attraction and past behavior and future predictions. In response to questions of complexity, Fritz (1993) expanded on Kinsey's continuum model to measure a person's past and future sexual attraction, behavior, fantasies, emotional preference, social preference, lifestyle, and self-identification.

Stroms (1978) offers yet different model of sexual attraction, a multiple-variable model, in which sexual attraction to different genders is examined independently of each other. In this model, Stroms' scale has one end representing no attraction to one gender and the other end presenting high attraction to that gender. The continuum offers great variation within this model. Although this model did not include transgender persons, a scale could be created for them. In

**Table 1.2** Stage theories of sexual identity formation

| Theorists | Population | Stages of identity formation |
|---|---|---|
| Ponse (1978) | Lesbian | *"Gay trajectory"*<br>Subjective feelings of difference from sexual/emotional desire for women<br>Understanding feelings as lesbian<br>Assuming a lesbian identity<br>Seeking company of lesbians<br>Engaging in lesbian relationship (sexual and/or emotional) |
| [a]Coleman (1982) | | Precoming-out<br>Coming-out<br>Tolerance<br>Acceptance<br>Pride<br>Integration |
| Minton and McDonald (1984) | Gay men | Egocentric<br>Sociocentric<br>Universalistic |
| [a]Faderman (1984) | Lesbian | Critical evaluation of societal norms and acceptance of lesbian identity<br>Encounters with stigma<br>Lesbian sexual experience (optional) |
| Sophie (1985/1986) | Lesbian | First awareness<br>Testing/exploration<br>Acceptance<br>Integration |
| Chapman and Brannock (1987) | Lesbian | Same-sex orientation<br>Incongruence<br>Self-questioning<br>Choice of lifestyle |
| Troiden (1988) | Men | *Spirals rather than linear*<br>Sensitization<br>Confusion<br>Assumption<br>Commitment |
| [a]Morales (1989) | Racial/ethnic minority LGB | Denial of conflicts<br>Bisexual versus gay/lesbian identity<br>Conflicts in allegiances<br>Establish priorities in allegiances<br>Integrate various communities |
| [a]Reynolds and Pope (1991) | Multiple identity formation | Passive acceptance of society's expectations for one aspect of self<br>Conscious identification with one aspect of self<br>Segmented identification with multiple aspects of self<br>Intersection identities with multiple aspects of self |
| [a]Isaacs and McKendrick (1992) | Gay men | Identity diffusion<br>Identity challenge<br>Identity exploration<br>Identity achievement<br>Identity commitment<br>Identity consolidation |

(continued)

**Table 1.2** (continued)

| Theorists | Population | Stages of identity formation |
|---|---|---|
| [a]Siegel and Lowe (1994) | Gay men | Turning point<br>Aware of difference<br>Identify source of difference<br>Coming-out<br>Assumption<br>Acceptance<br>Celebration<br>Maturing phase<br>Reevaluation<br>Renewal<br>Mentoring |
| [a]Fox (1995) | Bisexual | First opposite-sex attractions, behaviors, relationships<br>First same-sex attractions, behaviors, relationships<br>First self-identification as bisexual<br>Self-disclosure as bisexual |
| McCarn and Fassinger (1997); Fassinger and Miller (1996) | Lesbian and gay | Awareness<br>Exploration<br>Deepening/commitment<br>Internalization/synthesis |
| [a]Eliason (1996) | Lesbian | Cycles/not linear<br>Pre-identity<br>Emerging identity<br>Recognition/experiences with oppression<br>Reevaluation/evolution of identities |
| [a]Nutterbrock et al. (2002) | Transgender | Awareness<br>Performance<br>Congruence<br>Support |
| [a]Devor (2004) | Transgender | Abiding anxiety<br>Confusion<br>Comparison (birth sex/gender)<br>Discover trans identity<br>Confusion (trans)<br>Comparison (trans)<br>Tolerance (trans)<br>Delay before acceptance<br>Acceptance<br>Delay before transition<br>Transition<br>Acceptance of post-transition gender/sex<br>Integration<br>Pride |

Adapted from Eliason and Schope (2007)
[a]No empirical validation

addition, Strom's model includes people who tend toward asexuality. The model describes attraction to women and men as two separate variables (Burleson 2005).

*Theoretical State Stage Models*. In the USA, the 1970s ushered in a new era of research about sexual orientation identity development with the emergence of theoretical state stage models. The primary focus of these models was on the resolution of internal conflict related to identification as lesbian or gay and informed the "coming-out" process. Bilodeau and Renn (2005) describe these

**Table 1.3** Cass model of gay and lesbian identity formation

| | |
|---|---|
| Stage 1 | **Identity Confusion**—Personalization of information regarding sexuality. "Could I be gay?" This stage begins with the person's first awareness of gay or lesbian thoughts, feelings, and attractions. The person typically feels confused and experience turmoil |
| Task | Who am I?—Accept, deny, reject |
| Stage 2 | **Identity Comparison**—Accepts possibility one might be homosexual. "Maybe this does apply to me." In this stage, the person accepts the possibility of being gay or lesbian and examines the wider implications of that tentative commitment. Self-alienation becomes isolation |
| Task | Deal with social alienation |
| Stage 3 | **Identity Tolerance**—Accepts probability of being homosexual and recognizes sexual/social/emotional needs of being homosexual. "I am not the only one." The person acknowledges that she or he is likely lesbian or gay and seeks out the other lesbian and gay people to combat feelings of isolation. There is increased commitment to being lesbian or gay |
| Task | Decrease social alienation by seeking out lesbian and gay persons |
| Stage 4 | **Identity Acceptance**—Accepts (versus tolerates) homosexual self-image and has increased contact with lesbian/gay subculture and less with heterosexual. "I will be okay." The person attaches positive connotation to her or his lesbian or gay identity and accepts rather than tolerates it. There is continuing and increased contact with the lesbian and gay culture. |
| Task | Deal with inner tension of no longer subscribing to society's norm, attempt to bring congruence between private and public view of self |
| Stage 5 | **Identity Pride**—Immersed in lesbian/gay subculture, less interaction with heterosexuals. Views world divided as "gay" or "not gay." "I've got to let people know who I am!" There is confrontation with heterosexual establishment and disclosure to family, friends, coworkers, etc |
| Task | Deal with incongruent views of heterosexuals |
| Stage 6 | **Identity Synthesis**—Lesbian or gay identity is integrated with other aspects of self, and sexual orientation becomes only one aspect of self rather than the entire identity |
| Task | Integrate lesbian and gay identity so that instead of being the identity, it is an aspect of self |

Adapted from Cass (1979)

models as having the following characteristics: (a) begin with a stage, (b) describe individuals using multiple defense strategies to deny recognition of personal homosexual feelings, (c) include a gradual recognition and tentative acceptance, (d) have a period of emotional and behavioral experimentation with homosexuality, (e) involve a time of identity crisis, and (f) marked by the coming-out process. Although difference exists among the stage models, which illustrate the difficulty of using one model to understand the complex psychosocial process of the development of sexual orientation identity, their predominance and persistence in the research literature and in current educational practice suggest that they represent with some accuracy the developmental process (Bilodeau and Renn 2005).

The minority stress model (Brooks 1981; Meyer 1995) is useful in understanding aspects of sexual minority identity development for older LGBT adults and the impact of sociocultural issues on their lives. Based on this model, individuals in minority groups experience additional minority-related stressors that individuals who are part of the majority do not have to contend. The minority stress model is a consolidation of several theories and models that propose that minority persons experience chronic stressors and these stressors can lead to negative psychosocial adjustment outcomes. According to Meyer (2010), the minority stress model does not attempt to imply that sexual minorities have higher rates of psychosocial issues because of their sexual orientation and gender identity; rather, the model identifies the pathogenic conditions that stigmatize LGBT persons and treat them as inferior to heterosexual individuals. Minority stressors for LGBT persons include

experiences of discrimination, concealment or disclosure of sexual orientation/gender identity, expectations of prejudice and discrimination, and internalized homonegativity (Cox et al. 2011; Meyer 2003). Unlike ethnic and racial minority groups who experience minority stress, LGBT persons who experience sexual minority stress often do not receive support and understanding from their families of origin (Dziengel 2008). Minority stress in LGBT persons has been linked to higher levels of depression and negative health outcomes (Cox et al. 2009; Huebner and Davis 2007).

McCarn-Fassinger (1996) developed the lesbian identity development model, and Fassinger and Miller (1996) later validated the applicability of the theory with gay men (subsequently referenced in the literature as Fassinger's gay and lesbian identity development model), which examines identity development from a personal and a group perspective. The lesbian identity development model includes four phases: awareness, exploration, deepening/commitment, and internalization/synthesis. The use of "phases" is intentional to explicitly indicate flexibility that individuals revisit earlier phases in new or different contexts. The model explores attitudes of lesbians and gay men toward self, other sexual minorities and gender identity, and heterosexuals. A distinguishing aspect of Fassinger's model is that lesbians, gays, or bisexuals are not required to "come out" or to be actively involved in the lesbian, gay, or bisexual community.

A life span approach to sexual orientation development has been introduced an alternative to stage models. D'Augelli (1994) offers a "life span" model of sexual orientation development. This model takes social contexts into account in different ways than stage models. In addition, D'Augelli's model has the potential to represent a wider range of experiences than do the theories relating to specific racial, ethnic, or gender groups and addresses issues often ignored in other models. D'Augelli presents human development as unfolding in concurring and multiple paths, including the development of a person's self-concept, relationships with family, and connections to peer groups and community. This model suggests that sexual orientation may be fluid at certain times and more fixed at others and that human growth is intimately connected to and influenced by both biological and environmental factors. D'Augelli's model has six "identity processes" that function more or less independently and are not sequenced in stages (see Table 1.4). An individual may experience development in one process to a greater extent than another, and, depending on context and timing, he or she may be at different points of development in a given process (Bilodeau and Reen 2005).

**Table 1.4** D'Augelli life span model of sexual orientation development

| |
|---|
| Exiting homosexuality |
| Developing a personal LGB identity |
| Developing an LGB social identity |
| Becoming an LGB offspring |
| Developing an LGB intimacy status |
| Entering an LGB community |

D'Augelli (1994)

Renn and Bilodeau (2005) extended D'Augelli's (1994) model and applied it to understanding corresponding processes in the formation of transgender identity development. Bilodeau (2005) found that transgender persons describe their gender identities in ways that reflect the six processes of D'Augelli's model.

Since the inclusion of gender identity disorder (GID) for the first time in the diagnostic and statistical manual of mental disorders (DSM) in 1980 as a mental illness, other theories on transgender identity formation have been proposed by Nutterbrock et al. (2002) and Devor (2004), bisexual identity formation by Fox (1995), and multiple identity formation by Reynolds and Pope (1991) (Table 1.2); however, none of these models have been empirically validated. In the fifth edition of the DSM, GID was deleted and replaced with gender dysphoria (GD), indicating that it is not a mental illness, rather a lifestyle with which individuals may need assistance in making adjustments. Feminist, postmodern, and queer theoretical theorists (e.g., Butler 1990, 1993; Creed 1995; Feinberg 1996,

**Table 1.5** Lev's transgender emergence model

| | |
|---|---|
| Stage 1 | **Awareness**—Gender-variant people are often in great distress. The therapeutic task is the normalization of the experiences involved in emerging as transgender |
| Stage 2 | **Seeking Information/Reaching Out**—Gender-variant people seek to gain education and support about transgenderism. The therapeutic task is to facilitate linkages and encourage outreach |
| Stage 3 | **Disclosure to Significant Other**—Involves the disclosure of transgenderism to significant other. The therapeutic task involves supporting the transgendered person's integration in the family system |
| Stage 4 | **Exploration (Identity and Self-Labeling)**—Involves the exploration of various (transgender) identities. The therapeutic task is to support the articulation and comfort with one's gendered identity |
| Stage 5 | **Exploration (Transition Issues and Possible Body Modification)**—Involves exploring options for transition regarding identity, presentation, and body modification. The therapeutic task is the resolution of the decision and advocacy toward their manifestation |
| Stage 6 | **Integration (Acceptance and Post-Transition Issues)**—The gender-variant person is able to integrate and synthesis (transgender) identity. The therapeutic task is to support adaptation to transition-related issues |

Adapted from Lev (2004)

1998; Halberstam 1998; Wilchins 2002) have introduced alternatives to medical and psychiatric perspectives on gender identity. These theorists suggest that gender is not necessarily linked to biological sex assignment at birth, but is created through complex social inequities, and gender identity is more fluid. These theorists propose transgender identities and gender fluidity as normative as oppose to the binary, two-gender system and the influence of themes reflecting fluidity of gender that have emerged in the discipline of human development (Bilodeau and Renn 2005).

As an extension of sexual minority identity, in 2004 Lev introduced the transgender emergence model, a stage model that examines at how transgender people come to understand their identity. Lev's model comes from the perspective of a counseling or therapeutic point of view and focuses on what the individual is experiencing and the responsibility of the counselor or interventionist. As with other stage theories, Lev's model begins with the first stage as awareness. (see Table 1.5 for Lev's stages). Lev's clinical and philosophical ideology is based on the belief that transgenderism is a normal and potentially healthy variation of human expression. As postulated by Goldner (1988), gender dichotomies are not only restrictive, but also constitutive, with the gendering of social spheres constraining personal freedom and gender categories determining what is possible to know. Lev's approach is to consider the ecosystem (i.e., influence of environment on perception and behavior) in working with transgender persons. According to Lev, "gender variance does not simply live within individuals but exists 'within' a larger matrix of relationships, families, and communities" (p. xx).

Lev offers three goals for therapists working with transgendered persons and their families. The first goal is "to accept that transgenderism is a normal expression of human potentiality." The second goal is "to place transgenderism within a larger social context that includes an overview of the existence of gender variance throughout history." The third goal is "to outline various etiological theories that impact assessment and diagnosis, as well as innovative, possibly iconoclastic treatment strategies to work with gender-dysphoric, gender-variant, transgendered, third-sexed, transsexual, and intersexed people as members of extended family systems" (pp. xx–xxi).

## Counseling Theories and Practice for Older Adults

A commonly held view of older persons is that they are mentally incompetent. Although there is some cognitive decline associated with normal aging, the majority of older adults do not

demonstrate significant mental decline. For LGBT elders, psychosocial issues arise from ongoing discrimination on the basis of their sexual orientation and gender identity, lack of acceptance from the heterosexual community and family members, and isolation and exclusion from LGBT communities because of ageism. The general lack of support in many political, educational, and religious institutions and the distinctively oppressive social climate for sexual minorities in which older LGBT generations live creates personal conflict that can manifest itself through internalized disorders (e.g., depression, homophobia) or externalized disorders (e.g., suicidal behavior) (Mabey 2007). Counseling or therapeutic intervention can help LGBT elders who experience multiple discrimination to come to terms with factors associated with ageism (Sue and Sue 2013) and how the historically negative climate of discrimination and oppression shapes their experiences with, and impressions of, their own sexual identity (Heaphy 2007; Porter et al. 2004). However, it is important for counselors not to view identity as necessarily problematic (Berger 1982; Mabey 2011). In fact, researchers have introduced the concept of "crisis competence" or "stigma competence" (Almvig 1982; Balsam and D'Augelli 2006; Vaughan and Waehler 2010), in which coming-out by LGBT persons allows them to develop a competency for dealing with other crises or stigma in the life span, including difficulties associated with aging (Heaphy 2007; Kimmel et al. 2006; Schope 2005). Stigma competence was first developed with regard to persons from racial and ethnic minority groups who have multiple minority statuses, including sexual minority identity. In a study testing the theory of stigma competence with lesbian, gay, and bisexual adults over age 60, Lawson-Ross (2013) found that older sexual minority adults who were more accepting of their sexual minority identities had lower levels of internalized ageism and had higher levels of life satisfaction and happiness than their peers who were less accepting of their sexual minority identities.

*Counseling Approaches*. In working with LGBT elders, the selection of the counseling approach should be based on the individual and his or her needs. Counselors tend to adapt their approaches to working with a client based on the person's developmental changes in life, the particular cohort to which the person belongs, and the social context in which the person lives (Blando 2011). Older persons fit into a contextual, cohort-based, maturity-specific change model (Knight 1996) that suggests they face particular challenges that are unique in later life. Older LGBT persons belong to a particular cohort with a collection of experiences and norms that differ from those of the present and from heterosexual elders (Blando). In the remainder of this section, we will present select counseling approaches that may be effective with older LGBT populations. These counseling approaches are not intended to be either inclusive or suggestive; rather, they are a starting point or serve as guidelines.

One of the most common forms of therapy with the general population and with older adults is cognitive-behavioral therapy (CBT). CBT may be particularly efficacious with older adults because of its focus on the present, strict structure, emphasis on self-monitoring, psychoeducational orientation, and goal oriented. Adjustment may need to be made for older adults who have developmental changes such as speed of processing in intellectual configuration (e.g., later life of crystalized over fluid intelligence), emotional changes (i.e., emotions are more nuanced and complex and may include co-experience of discrepant emotions such as being both happy and sad), and the person's worldview (Blando 2011). CBT examines the role thoughts play in maintaining a problem, stress, or concern. Emphasis is on changing dysfunctional thoughts that influence behavior. The application of CBT with LGBT elders may be effective in addressing behaviors stemming from past experiences of discrimination with institutions and service providers, fear of homophobia-based victimization, and also from fear or anticipation of discrimination. In addition, Satterfield and Crabb (2010) demonstrated the effectiveness of CBT for depression in an older gay man.

Guided autobiography is another approach that is effective with older adults. Guided autobiography is used to help people understand and make meaning from their past through reading and sharing brief, written essays about their lives, and sharing their thoughts about these stories. It promotes integration, fulfillment, and competence (Blando 2011). LGBT elders often have not had a safe venue in which to explore or express their feelings, self-concept, or self-identity. Guided autobiography offers them a private mechanism to do so.

Another approach applicable to working with LGBT elders is persons-centered therapy (PCT) by Rogers (1951). Rogers described people who are becoming increasingly actualized as having four characteristics: (a) an openness to experience, (b) a trust in themselves, (c) an internal source of evaluation, and (d) a willingness to continue growing. PCT has emphasized on how individuals can move forward in constructive directions and how they can successfully deal with obstacles both within themselves and outside of themselves that are blocking their growth. Through self-awareness, an individual learns to exercise choice. The therapeutic goal is for an individual to achieve a greater degree of independence and integration (Corey 2103).

## Theories of Public Health and Practice

A number of important theories and approaches germane to public health are salient for LGBT elders. It is important that at least two distinguishing approaches are borne in mind regarding public health constructs. First, public health primarily concerns population health versus the health of individuals, and so, allowing for within-group differences, public health efforts concern the *population* of LGBT elders rather than the actions of individuals. Second, public health stresses the importance of prevention efforts above and beyond any other efforts. Though this is not to say that public health does not involve intervention, public health experts seek to improve the health of LGBT elders far earlier than most other discipline's current intervention efforts contemplate, for example, preventing poor health outcomes as a result of historic stressors and inequities, such as, until recently, the lack of health insurance coverage for same-sex partners. In this section, we explain four well-recognized approaches/theories to public health that have applicability to LGBT elders, in particular the socio-ecological model, the theory of reasoned action, the health belief model, and the transtheoretical model of change (DiClemente et al. 2013).

The first of these approaches is the socio-ecological model, most closely associated with Bronfenbrenner (1986). Applied to LGBT elders, the model places the elder at the center of four nested systems (depicted graphically as concentric circles), consistent with an "elder-centered" (Quandt et al. 1999) approach to prevention and intervention. The *microsystem*, which includes the older adult, includes biological and personal factors that converge to influence how individuals behave as well as risk factors for adverse health outcomes. Consideration of LGBT elders at the level of the *mesosystem* focuses on close relationships (e.g., family, friends, neighbors) in order to explore how such relationships either protect against or promote LGBT health and quality of life. The *exosystem* identifies community contexts in which social relationships occur (e.g., neighborhoods, service organizations). This system promotes how characteristics settings may affect LGBT elders' health and well-being. Finally, the *macrosystem* includes broad ideological values, norms, and institutional patterns that may foster a climate in which LGBT elders are either encouraged or prohibited, including changes in power and control dynamics (e.g., dominance of spouse/partner; reversal of child/parent roles) as well as age-related changes in social positions and financial resources.

One of the most well-known value-expectancy theories in public health is the theory of reasoned action, which grew out of research Ajzen (2002) and Ajzen and Fishbein (1980) on behavior and attitude. Central to this theory is that people have control over their lives and can consequently make a decision made about a

behavior to adopt or discontinue. The authors contend that an elder's beliefs and attitudes shape his or her intent to take an action and that social influences or norms on LGBT elders also affect behavioral intent. For example, if an LGBT elder believes that stopping smoking is a goal but that society would offer little help for him or her to do so because of a pervasive attitude that the elder's sexual orientation is causing the problem, then he or she is unlikely to attempt the change because the cost of doing so is too high or difficult.

Another type of theory or perspective is those concerning a perceived threat. Perhaps the most well known is the health belief model, which has been used by public health practitioners and researchers for over 50 years. The health belief model has similarities to the value-expectancy model above, but it is also a departure, due to the insertion of a threat or fear that drives changes in health behavior as well as a person's perception of health severity and his or her perception of health susceptibility (Salazar et al. 2013), and, added to the model in the late 1980s, the concept of self-efficacy (Bandura 1977) or an older adult's conception of his or her own power or self-determination (Rosenstock et al. 1988). The cost-benefit valuation determines the course of action, as it also does with the theory of reasoned action described above. A fear appeal might be used to promote a health behavior change, such as the threat of susceptibility to HIV in older adult populations.

A fourth and well-known stage is the transtheoretical model of change, a model explaining how persons may change their health behavior and derived from more than 300 theories of psychotherapy (Prochaska 1979; Prochaska and DiClemente 1986). Five stages, in which persons can facilitate, comprise the model: precontemplation, contemplation, preparation, action, and maintenance. Precontemplation is the stage when a person is not ready to attempt a change at all. In the contemplation stage, an elder is thinking of embarking on a change, and the impetus to act or not is the fulcrum of decisional balance. The scale must tip in favor of attempting the change rather than impediments to doing so. Preparation concerns undertaking some steps toward a change, such as talking to a doctor about a health condition or visiting another health professional to seek advice. The stage of action concerns undertaking an identifiable activity (e.g., walking, eating healthy foods, wearing a condom). Finally, the maintenance stage is when the change is adopted and the effort to continue the change diminishes from the action phase. Recidivism is possible, but continued progress decreases the chances of returning to the former and undesired behavior (Schneider 2013). High self-efficacy is critical to reach the maintenance stage (Bandura 1986).

## Social Work Theories and Approaches

One of the unique concepts of social work practice is an understanding of the constant state of change of the contextual arena in which social workers operate. With the continuous change in environments and populations, social workers need to rethink how they deliver services in response to distinct alterations in family structures and functions, medical advances and aging, economic shifts, and shifting evolving professional and political ideologies (Allen 2005). Gratwick et al. (2014) contend that theoretically driven service models are crucial to effective service provision. Similar to the other disciplines mentioned previously, various theories and model are used in social work practice. Social work practice employs the developmental theories of moral reasoning (Kohlberg 1973; Gilligan 1982), cognition (Piaget 1932), stage theories (Erikson 1950), and transpersonal theories of human development (going beyond identity rooted in the individual body or ego to include higher levels of consciousness). Developmental theories focus on the changes and stability of behavior across the life span. The remainder of this section concerns a presentation of these theories, the primary perspectives, and current social work practice models. Infused throughout is discussion on social work practice with LGBT elders.

The major theories used in social work practice are systems theory, psychodynamic, social learning, and conflict theory. Systems theory

(Bertalanffy 1968) is the interdisciplinary study of systems to identify and understand principles that can be applied reciprocal relationships between parts or elements that constitute a whole, and the relationships among individuals, groups, organizations, or communities and mutually influencing factors in the environment. A system is a set of elements that interact with one another. The system is only as strong as its weakest part, and the system is greater than the sum of its parts. The focus of this theory is on the interconnectedness of elements with all living organisms (systems) in nature and social relationships (Gladding 2011). Bertalanffy's model assumes a single-dimension cause-and-effect relationship between social elements within the environment. A demarcation of systems in social work involves the designation of particular social systems as being microlevel (small-size social system such as individual or couples), mezzo-level (intermediate-size social system such as support networks), and macrolevel (large-size social system such as communities and organizations) (Friedman and Allen 2011). It appears that the systems model, as it is applied to social systems, provides the social work practitioner the means to view human behavior through a comprehensive lens that allows for the assessment of the person across a broad spectrum of human conditions (Lesser and Pope 2011).

Carsetensen et al. (1999) introduced socio-emotional selectivity theory (SST), which builds upon the idea that social networks have value and maintains that the perception of time systematically influences motivation. A basic tenet is that the perception of time affects how people regulate their social environment and that those people who perceive time as finite spend their time optimizing relationships that are emotionally fulfilling. Adults are expected to contact their social networks and avoid unbeneficial relationships. LGBT elders have significantly diminished traditional supports when compared to the general older population (Lancet 2011), which translates into a lack of traditional support networks that may not be replaced by the strength of other close friends or informal support networks with the LGBT community (Irish Association of Social Workers 2011). Older LGBT adults suggest that they may not use or disclose when qualifying for or receiving services because they do not trust the social environment in which services are delivered or do not perceive potential relationships in these contexts to be emotionally supportive or fulfilling (Gratwick et al. 2014). Discussion Box 1.1 provides further information on the theoretical framework of SST. Older LGBT persons must perceive value in social networks in order to believe that they will benefit from them. Sullivan (2011) found that LGBT elders' decisions to enter LGBT senior housing were due to an LGBT-accepting social environment that increased their sense of safety to increase their social networks. The extent to which older LGBT individuals have social networks varies by gender. Schope (2005) found that the appearance of older gay men tended to be judged more negatively in the gay community, resulting in less social support. Conversely, lesbians tend to have more social networks comprised of lesbians across the age spectrum and are revered by younger lesbians for their insight and perceived political power. Older bisexual and transgender adult face greater challenges than their gay and lesbian peers with regard to stigma, discrimination and self-identity, and social networks because of their perceived lack of identity to either gay men or lesbians.

**Discussion Box 1.1: Socioemotional Selectivity Theory (SST)** SST presumes that goals are always set in temporal contexts and that the relative importance of specific goals within this goal constellation changes as a function of perceived time.

When the future is perceived as open-ended, future-oriented goals weigh most heavily and individuals pursue goals that optimize long-range outcomes.

When endings are perceived, goal constellations are recognized such that emotionally meaningful goals (related to feelings) are prioritized because such goals have more immediate payoffs.

Although achieved more gradually, approaching old age is also associated with increasing recognition that time is, in some sense, running out.

SST was originally formulated to explain and predict age differences in motivation. Because chronological age is associated with perceived time left in life, the theory predicts systematic age differences in motivation.

**Questions**:

1. Why are individuals more motivated toward goal constellation as they age?
2. Does SST consider a continuum in which individuals optimize goal-oriented outcomes?
3. How does SST explain the role of social networks for LGBT elders?

Adapted from Fung and Carstensen (2006).

Another approach, psychodynamic theory, also known as insight-oriented theory, has its origin in psychoanalytic theory, similar to the transdisciplinary change model in public health. The psychodynamic approach includes all the theories in psychology that regard human functioning as based on how interaction, drive and emotions, particularly unconscious processes as manifested in a person's present behavior. The goal of psychodynamic intervention is to increase a person's self-awareness and understanding of the influence of the past on present behavior. A psychodynamic approach enables a person to examine unresolved conflicts and symptoms that arise from past dysfunctional relationships and manifest themselves in the need to engage in abusive and dysfunctional behavior (Haggerty 2006). The theory purports that emotions have a central place in human behavior and both conscious and unconscious mental activity serves as the motivating force in human behavior (McLeod 2007). Individuals may become overwhelmed by internal and/or external demands and frequently use ego defense mechanisms to avoid becoming overwhelmed. Social workers use this theory when addressing early attachment relationships and the developmental history of the individual, which includes past trauma. The therapeutic techniques used include transference, dream and daydream analysis, confrontation, focusing on strengths, life history, and complementarity. Typically linear, psychodynamic-oriented therapy focuses on cause-and-effect interactions (Gladding 2011).

Social learning theory (SLT) (Bandura 1971), also used by public health, operates from the hypothesis that human behavior is learned as individuals interact with their environment. People learn through observing others' behavior, attitudes, and outcomes. Individuals observe others and learn through modeling. From observing others, an elder forms an idea of how new behaviors are performed and later this coded information serves as a guide for action. SLT explains human behavior as continuous reciprocal interaction among cognitive, behavioral, and environmental influences (reciprocal determinism). SLT is regarded as a bridge between behaviorist and cognitive learning theories because it encompasses attention, retention, reproduction, and motivation. Problematic behavior is maintained by positive or negative reinforcement. Cognitive-behavioral therapy examines the role that thoughts play in maintaining a problem, and its emphasis is on changing dysfunctional thoughts, which influence behavior. Social learning theory has been used extensively with younger LGBT persons, especially in the area of career choice. SLT applied to LGBT elders can be effective in working with substance abusers. For example, Bowman and Bryant (2011) applied SLT to understand smoking behavior among LGBT persons because compared to the general population, LGBT adults have significantly higher smoking rates. One plausible explanation for the higher rates is that the tobacco industry targets the LGBT community. Bowman and Bryant found that LGBT persons often start smoking after "coming-out" in direct response to social stresses and gay culture, which seems to be support smoking behavior.

Conflict theory, introduced by Karl Marx (cited in Dobb 1979) as the name implies, involves conflict, dominance, and oppression in social life. Basically, groups and individuals attempt to advance their own interests over those of others. However, because power is unequally divided, social order is based on manipulation and control of non-dominant groups by dominant groups. In the case of LGBT elders, heterosexuals and younger groups exert domination through heterosexism and homophobia. Depending on other group affiliations of LGBT persons (e.g., race/ethnicity, socioeconomic status), they may be further dominated. Conflict theory is further characterized by a lack of open conflict as a sign of exploitation. Social change is driven by conflict, with periods of change interrupting long periods of stability. Social workers use conflict theory to understand those experiencing oppression in some form or another in society. Research indicates that LGBT elders experience oppression (e.g., political, religious, economic, cultural) and marginalization (e.g., sexual orientation, gender identity, age) from numerous sources. For example, in a study of the prevalence of mental disorders in LGBT persons, Meyer (2003) found a higher prevalence of mental disorders than in heterosexual persons. He attributed this to minority stress, explaining that stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems. Application of conflict theory helps LGBT elders to deal with a history of homophobia and discrimination, experiences of antigay gay violence and hate crimes, addressing public opposition to gay marriage, expectations of rejection, internalized homophobia, hiding and concealing identity, and ameliorative coping processes.

Perspective in social work practice represents the specific aspects of a session that are emphasized. The primary perspectives used in social work practice include strengths (Saleeby 1996) or resilience, feminist, and ecosystem. The social worker believes that a person has multiple strengths that are assessed and incorporated into the helping relationship. Although resilience has various definitions, at times it is "defined as a psychological process developed in response to intense life stressors that facilitate healthy functioning" (Ballenger-Browing and Johnson 2010). Resilience has four prerequisites: (a) risk or predisposition to biopsychosocial or environmental conditions, (b) exposure to a high-magnitude stressor, (c) stress response, and (d) return to baseline functioning and symptom levels (Ballenger-Browning and Johnson 2010, p. 1). The feminist perspective takes into account the role of gender and the historical lack of power experienced by women in society. Social workers using this perspective emphasize equality and empowerment of women in society. Application of the feminist approach with LGBT elders would place emphasis on equality with regard to sexual orientation, gender identity, age, and other characteristics of the populations. Finally, the ecosystem (Germain 1973) is the person-to-environment concept presented earlier in this chapter. According to Mattaini and Meyer (2002), the ecological system has been almost universally accepted in social work practice because of its framework for understanding network complexities.

Social work practice model provides step-by-step guides for client sessions. The current social work practice models include problem-solving, task-centered, solution-focused, narrative, cognitive-behavioral, and crisis. In the problem-solving approach, one must first understand the presenting problem or issue and then brainstorm possible solutions. It is incumbent upon the person or client to select a solution, implement it, and evaluate its effectiveness. The task-centered model focuses on breaking down the problem into small manageable tasks, thus facilitating accomplishment. The solution-focused model takes the approach of identifying the solution first and having the person establish the process that will lead to the solution. Finally, the narrative model uses a variety of method for the person to express his or her thoughts.

## Integration of Practice Models in Working with LGBT Elders

Understanding how models work can work effectively in support of LGBT elders is necessary to improving service outcomes. When drawing from theories from the disciplines represented in this chapter, it is efficacious to consider bringing them together from an interdisciplinary perspective (some cross one or more disciplines anyway). Tan (2009) suggests that many in the field of social work remain too focused on individual therapy and clinical practice when there is a need to shift more globally and holistically. Furthermore, progressive social work place more emphasizes on the need for the individual to be part of his or her own change (Mullaly 2002). Tan suggests that community development theory (CDT) is a practical framework. Community development theory is defined as "the employment of community structures to address social needs and empower groups of people" (Mendes 2008, p. 3). CDT is rooted in sociology. Its primary functions are to provide norms for the practitioner's actions and a model of practical help to communities. CDT depends heavily on general systems and on the conceptual frameworks of social systems, thus treating communities as systems (Cook 1994). Tan purports that the principles of CDT have implications for the ways clinicians view and engage with clients and ways social workers seek to make large-scale changes within the community.

A key to application of CDT to LGBT elders is the notion that people involved in a system have a sense and recognition of the relationships and areas of common concerns with other members. For LGBT elders, the community may be their immediate surroundings as well as regional, national, or international organizations with which they have affiliation or that provide services and advocacy on their behalf. Because many theories are used in community development, the holistic approach of CDT consciously attempts to emphasize on the functional relationship among the parts and the whole. Given the variety and degree of services that LGBT elders need, CDT offers a way of looking at the interconnectedness of services and activities from an operational level intended to improve outcomes. Moreover, CDT values and principles potentially empower LGBT elder to be involved in their community to have input on decisions that may influence them.

Several practice models have been developed to assist in older LGBT adults, ranging from guidelines for practice to specialized support groups and approaches to individual therapy (Hash and Rogers 2013). The American Psychological Association (APA) developed the Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients (www.apa.org/pi/lgbt/resources/guidelines.aspx) (APA 2012), the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC 2009) developed competencies for counseling LGBT clients, and ALGBTIC in conjunction with the American Counseling Association (ACA 2010) approved competencies for counseling transgender clients. The code of ethics of the National Association of Social Work (NASW 2008) (http://www.socialworkers.org/pubs/code.asp) emphasizes the importance of cultural competency and social diversity, including sexual orientation and gender identity, as does the Code for Professional Ethics for Rehabilitation Counselors (www.crccertification.com/filrbin/pdf/crcCodeOfEthics.prf) (CRCC 2010). The Centers for Disease Control (http://www.cdc.gov/lgbthealth/) emphasize the importance of addressing disease in the LGBT community across the life course, particularly as it concerns HIV and other sexually transmitted diseases as well as violence prevention and intervention (CDC 2014). The Council on Social Work Education (CSWE) has incorporated issues relevant to sexual orientation (www.cswc.org/File.aspx?id=25501) (CSWE 2008). Through an examination of the unique strengths and challenges faced by older LGBT adults, Crisp et al. (2008) constructed a profile and suggested an age-competent and gay affirmative model for practice, including culturally competent knowledge, attitudes, and skills for work with older LGBT adults in the USA.

Building social networks to address challenges faced by LGBT elders who share similar experiences and backgrounds is offered as a way to build an effective modality (Hash and Rogers 2013). In a technological era, the use of cyber counseling has the potential to deliver services to LGBT elders within their residential setting without requiring them to travel for services. However, it is important to recognize that some LGBT elders do not have access to technology or do not have technology literacy.

## Summary

In conclusion, theories from the disciplines presented here (i.e., counseling, public health, and social work) are replete with theories that are discipline specific but also that draw upon other disciplines, in particular those from psychotherapy and sociology. Consistent among those presented is an understanding of LGBT elders from the perspectives of stages of development or progress, of interlocking systems and networks, of the influence of the environment, of costs and benefits, of holism, and of interdisciplinarity. Not intended to be exhaustive, this chapter has presented major theories, frameworks, and concepts necessary to provide human services for the LGBT population. These frameworks, either explicitly or implicitly, undergird the rest of the chapters of the book as well as provide a touchstone for understanding the unique perspective presented.

## Learning Exercises

### Self-Check Questions

1. What is the function of theory for practitioners?
2. Even when providers of aging services express willingness to become more responsive to the needs of LGBT older adults, what usually are the outcomes?
3. In which of Erikson's stages of psychosocial development is it more complicated for an LGBT elder to accept one's life and self? Explain why?
4. What are the similarities between Sigmund Freud and Erving Goffman's concepts about childhood development?
5. What is the difference between a theory, a construct, and a model?

### Experiential Exercises

1. Select a theory and apply the concepts in a role-play situation to LGBT elders in a group counseling session or self-advocacy activity.
2. Given current theories, constructs, and models, identify what is a gap and propose a model for application to LGBT elders for counseling and/or service delivery.
3. Select a theory in a specific discipline and deconstruct it through a critical analysis in its shortcoming for application to LGBT elders.

### Multiple-Choice Questions

1. Who was one of the first theorists to present identifiable stages of homosexual identity?
   (a) Rogers
   (b) Skinner
   (c) Plummer
   (d) Gladding
2. The Kinsey scale clarified which of the following issues about sexuality?
   (a) Individuals are strictly heterosexual or homosexual
   (b) There is greater variability of sexual orientation
   (c) Heterosexuality is not primary or held above other sexual orientations
   (d) Both B and C
   (e) All of the above
3. How does the minority stress model apply to LGBT persons?
   (a) Identifies pathogenic conditions that stigmatize LGBT persons and treat them as inferior to heterosexual individuals

(b) Attempts to imply that sexual minorities have higher rates of psychosocial issues because of their sexual orientation and gender identity
(c) Confirms LGBT sexual identity as a mental illness
(d) Supports the notion that gender is socially defined

4. Which of the following developed the transgender emergence model?
   (a) McCarn-Fassinger
   (b) Lev
   (c) D'Augelli
   (d) Devor
5. Which therapy may be particularly effective with older adults because of its focus on the present, emphasis on self-monitoring, psychoeducational orientation, and goal orientation?
   (a) Person-centered therapy
   (b) Psychoanalytic therapy
   (c) Cognitive-behavioral therapy
   (d) Existential therapy
6. Which of the following is of primary concern for public health?
   (a) Health of individuals
   (b) Population health
   (c) Immigrant populations
   (d) Underserved groups
7. Which theory emphasizes that people have control over their lives and can consequently make a decision about a behavior to adopt or discontinue?
   (a) Theory of reasoned action
   (b) Centrality theory
   (c) Snowball theory
   (d) Gestalt theory
8. Which theory has as it basic tenet that the perception of time affects how people regulate their social environment and that those who perceive time as finite spend their time optimizing relationships that are emotionally fulfilling?
   (a) Reality theory
   (b) Feminist theory
   (c) Behavior theory
   (d) Socioemotional selective theory
9. Which theory hypothesizes that human behavior is learned through observing other's behaviors and through modeling?
   (a) Ecological theory
   (b) Systems theory
   (c) Social learning theory
   (d) Solution-focused theory
10. Which theory is defined as the use of community structures to address social needs and empower groups of people?
    (a) Community action theory
    (b) Community development theory
    (c) Family systems theory
    (d) Action development theory

### Key

1-c
2-d
3-a
4-b
5-c
6-b
7-a
8-d
9-c
10-b

## Resources

American Counseling Association: www.counseling.org.

Association for Adult Development and Aging: www.aadaweb.org.

Association for Lesbian, Gay, Bisexual, & Transgender Issues in Counseling: www.algbtic.org.

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National Association for Social Workers: www.socialworkers.org.

National Gerontological Society of America: www.geron.org.

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