
Deconstructing Multiple Oppressions Among LGBT Older Adults

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Abstract

The purpose of this chapter is to interrogate oppression through an analysis of discourses related to lesbian, gay, bisexual, and transgender (LGBT) older adults. As part of our reflexive posture, we attend to the social constructions of meaning about age, ability, gender, race, and sex and their colossal impacts on LGBT older adults. We are mindful of the weight of oppression for LGBT older adults in general but in particular overlooked subgroups of this diverse population (e.g., people who are with low income, people of color, and people who are transgender and do not fit into the binary of woman or man, gay or straight). We confront multiple layers of discrimination by deconstructing cultural assumptions of normalcy (e.g., heteronormativity within the LGBT community) presented in visual form, verbal text, and within discourses.

Keywords

LGBT elders · Ageism · Racism · Homophobia · Transphobia · Multiple oppressions

Overview

In this chapter, we examine gender and sexuality, race, privileged queer identities, and policy issues affecting lesbian, gay, bisexual, and

transgender (LGBT) older adults. A case study with discussion questions concludes our work. The following tenets guide our formulations and constructions of meaning: (1) Sexuality is fluid; (2) there is a difference between LGBT identity and same-sex behavior; (3) differences as well as inequities exist within the LGBT population and mirror the differences and inequities that exist among non-LGBT and the under-65 population; (4) there is inadequate attention devoted to ethnic and racial diversity among LGBT older adults; (5) there is inadequate attention devoted to transgender issues in the research on LGBT older adults; and (6) patriarchy and racism produce and

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perpetuate silence about race and transgender among LGBT older adults.

As authors, we bring our lens, biases, and positions to the writing of this chapter. We acknowledge our subjectivity informed by our location within multiple identities. We are heterosexual and lesbian, faculty member and graduate student in counseling psychology, black and white, married and single, and baby boomer and millennial. Despite our differences, our similarities are greater and galvanize us to speak truth to power. We monitor our proximity to a multitude of live discourses in our interactions with LGBT people and clients. We have queried ourselves and one another about the unconscious and/or unspoken discourses that lie beneath socially constructed categories of difference relative to LGBT older adults.

Learning Objectives

Upon completion of this chapter, the reader should be able to:

1. Understand the role of discourses in the lives of LGBT individuals in general and for LGBT elders, in particular.
2. Understand the multiple impacts of racism, sexism, homophobia, transphobia, and biphobia on the LGBT older adult population.
3. Understand the roles of policies and laws on older LGBT individuals.

Introduction

Within the last few years, the United States of America (USA) has witnessed dramatic changes regarding who can legally marry. As of the writing of this book, nineteen states now sanction marriage between two women or two men. The heterosexist discourse is being challenged that dictates that marriage between a normal XY male and a normal XX female is the only acceptable union that warrants legal protection. Another

major cultural shift pertains to people with 65 years of age and older. Older adults are living and working longer than ever before. Although the actual numbers are inaccurate, millions of older adults are LGBT. In not being young and not being heterosexual, LGBT older adults are distinguished by multiple identities that run counter to the dominant culture's fascination with and insistence on youth, beauty, and traditional gender roles (Robinson-Wood 2013).

Ageism or age discrimination is fueled by a cultural belief that people who are middle-aged and older are past their prime, disabled and unproductive that denies the vast diversity among old LGBT adults. Although successful aging refers to the physical and emotional ability to thrive, cope, socialize, and learn (Van Wageningen et al. 2013), the USA culture places considerable emphasis on anti-aging, youth, and the body beautiful (Robinson-Wood 2013). Ageism and ableism intersect and are codependent on one another for their existence.

Gender prescriptions normalized by heterosexuals extend to LGBT populations. Moreover, the social construction of race is evident within the LGBT community. LGBT individuals of color experience more psychological distress, financial instability, limited access to culturally competent care, and housing inequality than their white counterparts.

Discrimination occurs among most LGBT older adults; however, vast intragroup differences exist and are related to disability, age, gender status, race, income, the quality of aging, and identity development. An LGBT older adult, who is transgender, single, working class, a person of color, and resides with friends in an apartment, lives in a society where his or her gender, sexuality, and marital status are inconsistent with cultural values such as patriarchy, heterosexual marriage, home ownership, economic success, and reproduction. Conversely, the middle-class gay male, who is married to and living with his husband, has children, and owns a home, occupies identity statuses that are culturally privileged and valued.

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reflexive posture, we attend to the social constructions of meaning about age, ability, gender, race, and sex and their colossal impacts on LGBT older adults. We are mindful of the weight of oppression for LGBT older adults in general but in particular overlooked subgroups of this diverse population (e.g., people who are with low income, people of color, and people who are transgender and do not fit into the binary of woman or man, gay or straight). We confront multiple layers of discrimination by deconstructing cultural assumptions of normalcy (e.g., heteronormativity within the LGBT community) presented in visual form, verbal text, and within discourses.

Self-Check Exercise: What kind of messages did you receive from your family about LGBT people and the elderly? What is your proximity to current discourses about LGBT elders? Do you know any persons who are LGBT elders?

Weedon (1987) defined *discourses* “as ways of constituting knowledge, together with the social practices, forms of subjectivity, and power relations which inhere in such knowledge and relations between them. Discourses are more than ways of thinking and producing meaning, they constitute the ‘nature’ of the body, unconscious and conscious mind, and emotional life of the subjects they seek to govern” (p. 105). Discourses can be subtle, yet they are pervasive throughout society and hold enormous power. Discourses can be unconscious. They can be insidious in that people are unaware of where they are located within and positioned by certain other discourses (Robinson-Wood 2013).

Discourses portray older people as homogenous, feeble, disabled, unproductive, asexual, unattractive, and forgetful (Robinson-Wood 2013). The tenets of patriarchy privilege LGBT older adults whose lives are most closely aligned with dominant cultural values and norms. In America, marriage, youth, gender conformity, wealth, ability, heterosexuality, and white skin operate as valued identities and commodities.

Falling outside of this cultural swath has significant implications for financial stability, employment, dating, marriage, access to and quality of health care, and social capital.

Discussion Box: Can you think of any movies (non-musicals) where LGBT elders have been depicted? What were their lives like? What race were they? How similar were their lives to cultural values? How do movies reinforce dominant cultural values and often perpetuate race, gender, and sexuality stereotypes?

LGBT Older Adults

Within the next 15 years, the number of older adults in the USA will nearly double, from 38 to 72 million. In 2030, one in five Americans will be 65 or older (Grant et al. 2010a). Between 2012 and 2030, the non-Hispanic white population is expected to increase by 54 % compared to 125 % for older racial and ethnic minority populations, including Hispanics (155 %), African Americans (104 %), American Indian and Native Alaskans (116 %), and Asians (119 %) (US Department of Health and Human Services 2012). Widely represented among LGBT older adults are people of color: black (non-Hispanic), Hispanic, American Indian or Native Alaskan, Asian or Pacific Islander. See Chaps. 6–8, and 10 respectfully, for further discussion on these groups.

Self-Check Exercise: What does deconstruction mean to you? How does deconstruction take place within society? Social construction suggests that society creates race, gender, and sexuality as meaningful categories of privilege and oppression among people. Society makes sense of these meanings, and difference is created rather than intrinsic to a phenomenon. Deconstruction is taking part; unlearning;

analyzing the way that meaning was constructed; and engaging in a different process of social construction with different meanings and outcomes.

Health and policy researchers have examined the implications of this dramatic increase in the numbers of older adults with respect to Medicare, the sustainability and availability of social security, healthcare affordability, retirement pensions, and tax revenues. LGBT older adults have recent scant attention from researchers. Approximately 3.5 % of the adult population or 8 million adults in the USA are lesbian, gay, or bisexual. Over 700,000 people are transgender (The Williams Institute, 2011). Due largely to advances in health care, aging baby boomers are living longer than those in previous decades. There are also significant numbers of LGBT people among aging baby boomers. Nonetheless, LGBT aging has been grossly understudied in health research.

Examining 2010 Census data, demographer Gary Gates (August 25, 2011) from the Williams Institute Study reports that in the USA there are 901,997 same-sex couples who are represented in 99 % of the counties. The 2010 Census included LGBT persons; however, marital status was queried but not sexual orientation. For instance, a woman living with another woman to whom she is not married could check the “unmarried partner” box. According to Gates (2011), as many as 15 % of same-sex couples were not identified as same-sex couples in the 2010 Census. Approximately 10 % of same-sex couples described their relationship as “roommates” or “non-relatives” and not as “spouses” or “unmarried couples.” When queried further, researchers learned that confidentiality was a concern among one-quarter of respondents. One-third took issue with the Census for not asking about sexual orientation or gender identity. Some people were offended by the options presented to them.

The actual percentage of the LGBT population is a complex issue. People can and do, for a

variety of reasons, conceal and/or camouflage their sexuality. The invisibility of LGBT sexuality and, in some cases, lack of disclosure about one’s sexual status presents methodological obstacles to research investigations on aging. The fluidity of sexuality over time and the nebulous nature of defining LGBT identity confound the methodological difficulties involved with researching this population. Estimates of persons who report any lifetime same-sex sexual behavior and any same-sex sexual attraction are substantially higher than estimates of those who identify as lesbian, gay, or bisexual. The distinction between behavior and identity may be illuminating. An estimated 19 million Americans (8.2 %) report that they have engaged in same-sex sexual behavior. Nearly 25.6 million Americans (11 %) acknowledge at least some same-sex sexual attraction.

According to Rust (2006), a person’s “sexual landscape might change, thus creating new opportunities for self-description while transforming or eliminating existing possibilities” (p. 174). LGBT individuals may be recently out, whereas others have been out for a lifetime since adolescence or early adulthood. Others lived primarily heterosexual lives and came out during middle adulthood. Some people have lived a portion of their lives according to a particular sexual orientation and have, with time, come to question their sexuality.

Methodological challenges withstanding in researching this largely invisible population (Shankle et al. 2003), recent research has begun to explore the unique issues LGBT older adults face. Pressing issues include these: (1) social isolation from communities of support; (2) identifying suitable and affordable LGBT-friendly housing; (3) elder abuse; (4) financial instability; and (5) health concerns related to aging (Grant et al. 2010a; Hash and Rogers 2013; Sargeant 2009; Fredriksen-Goldsen and Muraco 2010; Graham 2011; Hudson 2011; SAGE 2010). Research on the intersection of race and LGBT older adults has begun and is spearheaded by Services and Advocacy for GLBT Elders (SAGE) and the National Resource Center on LGBT Aging.

Gender and Sexuality

Gender refers to the complex interrelationship between those traits and one's internal sense of self as male, female, both, or neither as well as one's outward presentations and behaviors related to that perception (American Psychological Association 2006). Whereas sex refers to the XX and XY chromosome pairs for genetically healthy female or male (Atkinson and Hackett 1998), gender is a crucial part of identity presentation and representation across the life span. Although the meaning of gender varies among different cultures and changes throughout time (McCarthy and Holliday 2004), the most common definition refers to culturally determined attitudes, cognitions, and belief systems about females and males. Sex, gender, and gender expression are formed from interactions with parents, peers, and teachers and transmitted through the educational system, religious institutions, politics, and the media.

Gender marginalization can be found within the LGBT older adult community. Due to sexism or the institutionalized system of inequality based on the biological and social stratification of gender, LGBT individuals who are born male enjoy privileges that women and transgender persons do not. More specifically, power and privilege are conferred upon men who are viewed as masculine, powerful, and wealthy and conferred upon women who are regarded as attractive and emotionally available and pliable. As forms of expressions of one's gender, masculinity and femininity are shaped by traditional gender roles. Masculinity discourses embody men as aggressive, strong, and in control (much like America herself), whereas feminine discourses include female submission to men and masculinity validation. Lesbians, across age groups, suffer from gender discrimination by virtue of their sex and also due to a failure to compliment men as sexual and emotional partners (Sargeant 2009).

Discussion Box: Lesbians, across age groups, suffer from gender discrimination by virtue of their sex and also due to a failure to compliment men as sexual and

emotional partners (Sargeant 2009). Do you think this applies to lesbian elders?

Cisgender individuals are those who have gender-confirming identities where biological sex and gender match. This sex-gender congruity affords privilege and a cover of normalcy within society. Conversely, gender non-conformity refers to an individual's gender identity that does not align with biological sex; however, one's view of their sex is consistent with their sex at birth. Individuals who are gender non-conforming and transgender/transsexual (e.g., trans*) contest the dominant model of gender identity. People who are trans* may be biologically one sex but identify emotionally, physiologically, and psychologically with another sex or gender expression. They may identify as gay, lesbian, bisexual, or heterosexual. A male-to-female transsexual who has completed gender-confirming surgery might say: *I see myself being with a man, but I did not see myself as a man with a man. I saw myself as a woman with a man.*

According to the Diagnostic Statistic Manual of Mental Disorders (DSM)-5, people who are transgender have gender dysphoria. The DSM-5 is the diagnostic authority relied upon by all mental health clinicians to classify diagnostic codes for their patients, but this diagnosis can be controversial with people who are trans* and trans* rights advocates. Required for third-party billing, the DSM-5 has more than a 60-year history in the USA. Transgender is an umbrella term for people whose gender identity differs from that which is typically associated with their sexual assignment at birth. Often a source of confusion, transgender is not synonymous with homosexuality. Various transgender terms exist, including transsexual, genderqueer, transman, and transwomen.

Across race, class, culture, disability, and sexuality, gender influences what we believe about ourselves and others. Gender labels are applied to people, and, once assigned, people behave toward individuals based on a set of

expectations for persons with the same label. Deviation from prescribed gender roles attracts notice and comment from a scrutinizing public. At the center of cultural and gender normativity is patriarchy through which gender oppression is maintained. Among older people, gender is eclipsed by age unless it is nestled within youthfulness or age defiance. Among people of color, gender tends to be obscured by race, in that race vies for more attention as the salient identity construct (Robinson-Wood 2013).

Social constructions of gender and sexual identity impact one's lived experience. The visible signs of aging that mark a person as undesirable or unappealing are a phenomenon in the LGBT community (Sargeant 2009). Ageism in the gay community is rampant with gay men being particularly vulnerable to becoming "too old" for relationships if over the age of 35 (Sargeant 2009). Gay and bisexual men are twice as likely to live alone as heterosexual men. Gay and bisexual men tend to have a harder time successfully aging, and they seemed to be overwhelmed and even depressed, in comparison with lesbian and bisexual women (Macdonald and Rich 1983; Schope 2005). Feminism has exerted a tremendous impact on the formation of lesbian and bisexual women's communities, thus inspiring resistance to and confrontation of ageism (Grant et al. 2010a).

Gay and bisexual men appear to have had little connection to dialogues in which queer women have participated (Grant et al. 2010a). The youth orientation of gay culture has helped to cultivate internalized ageism among some gay and bisexual men who feel rejected and isolated from the mainstream gay community. Schope (2005) took a different position and argues that gay men are actually better able to cope with aging than are heterosexual men.

Although lesbian and bisexual women are more likely to live alone than heterosexual women (Grant et al. 2010a), lesbians seem to fare better than their gay counterparts and have broader social support networks and community involvement. Many lesbians enjoy intimate and sexual relationships well into older adulthood (Kimmel et al. 2013) and are less likely to be

viewed as unattractive as they age. The heteronormative standard of beauty has been critiqued by many older lesbians who refuse to be bound by body image ideals that harass heterosexual women (Kimmel et al. 2013). Although older lesbians are likely to be welcomed, respected, and even "treasured" by younger lesbians (Schope 2005), the challenge with this endearment is the perception of being patronized (Macdonald and Rich 1983).

Unlike the majority of lesbian, gay, and bisexual (LGB) individuals, many trans* individuals decide to transition later in life after retirement and after adult children have moved out of the house (Kimmel et al. 2013). The economic means to live one's gendered and sexual identity exists for many older trans* individuals; nonetheless, problems remain with dating, finding culturally competent healthcare providers, and coexisting within a marginalizing society. Little research is available on trans* individuals and how they live in older adulthood.

Privileged Queerness

Queer theorists have excluded LGBT older adults from their research in much the same way that LGBT older adults have been excluded from health care, policy, and mental health research. Brown (2009) argued that the producers of queer and gerontological theory communicate from a position of power that both silences and ignores the realities of LGBT older adults. She argues that homophobia, heterosexism in gerontology, and ageism in queer theory drive this production.

Halberstam (2005) identified two new terms in queer theory that have direct implications for LGBT older adults. Queer time and queer space is a model for minimizing the heteronormative gaze of aging. A new queer version centers on the present and is not focused on biological reproduction and the traditional family. Queer time and queer space questions the mainstream definition of healthy development and identity politics. Brown (2009) proposed that this perspective of living for today may have emanated

from the AIDS epidemic during the 1980s, which had a profound and lasting impact on the LGBT community. Brown (2009) also postulates that queer theory has historically focused on the young, creating a power differential and a dismissal of LGBT older adults' voices, bodies, desires, and perspectives.

Research and media on LGBT individuals ignores stratification and diversity within the LGBT community. Television shows such as *The L Word* and *Will and Grace* made a valiant attempt to empower and give voice to LGBT individuals. LGBT portrayals were overwhelmingly problematic because they presented people in stereotypical and sensationalized fashion (Akita et al. 2013). Far too often, a preferred type of LGBT person blankets the media. Despite the number of prime time television shows that give voice to the LGBT experience, such as *Orange is the New Black* and *Gray's Anatomy*, more often than not, media reflect dominant discourses concerning which LGBT individuals are worthy of watching. People who are young, attractive, white, wealthy, promiscuous, dramatic, gender-conforming, and physically fit are iconic. Most LGBT individuals and heterosexuals do not resemble these unrealistic television images.

A bifurcated and binary system of gender and gender expression is still imposed at this point in the twenty-first century. Within this system some, albeit not all, LGBT individuals are positioned at the periphery of mainstream society, which can increase one's susceptibility to oppression, prejudice, and stereotyping. Adherence to a binary gender and sexuality system contributes to discrimination against bisexuals within the LGBT community. Men and women who identify as bisexual experience biphobia and may not be considered as serious romantic partners or are perceived to be in transition or experimenting sexually, similar to adolescence. Bisexuals and trans* individuals have historically been silenced and excluded with many regarding them as part of the "out group" within LGBT organizations and movements (Graham 2011). Little research is available on internalized transphobia and ageism within the trans* older adult population.

Internalized homophobia can cause serious mental health effects and is fairly prevalent in the LGBT older adult population. Although many LGBT older adults are typically well adjusted and mentally healthy (Graham 2011), the Aging Health Report (Fredriksen-Goldsen et al. 2011) stated that 26 % of the 2500 LGBT older adults in the project tried at one time or another to *not* be lesbian, gay, bisexual, or transgender. On a scale of 1–4 with 4 representing higher levels of stigma, the average level of stigma on a nine-item measure adapted from the Homosexuality-Related Stigma Scale was 1.5 for LGBT older adult participants; 1.3 for lesbians; 1.5 for bisexual women; 1.5 for bisexual men; and 1.8 for transgender older adults.

Multiple Oppressions Among and Between LGBT Older Adults

Defining systems of oppression is critical to a thoughtful analysis of the history of LGBT people during the twentieth and twenty-first centuries. Pre- and post-WWII era policies banned LGBT individuals from serving in the military. In 1952, the Diagnostic and Statistical Manual of Mental Disorders (DSM-I) published by the American Psychiatry Association referred to homosexuality, pedophilia, and sexual sadism (e.g., rape and mutilation) as sexual deviation. WWII and the DSM were watershed events that perpetuated a cultural belief about homosexuality—that it was pathological, immoral, deviant, and unpatriotic. LGBT individuals were banned from mainstream society; however, wartime accelerated social changes, providing recruits who joined the military with an opportunity to escape to large cities. Such an exodus served to jump-start the formation of large LGBT communities.

Senator McCarthy was intent on excising identifiable LGBT individuals from government positions through arrests, blackmail, and coercion. Many private businesses followed suit. LGBT individuals living through pre- and post-WWII were largely closeted. Exorbitant amounts of energy were spent cloaking the

vestiges of their sexual orientation. Being out as a gay person was a serious threat to the state, personal safety, occupational, and residential security (Shankle et al. 2003).

A turning point for the social liberation of the LGBT community was Stonewall, a 1969 protest against police discrimination and brutality faced by countless openly LGBT individuals. The post-Stonewall generation is characterized by individuals who came of age during a period in history where homosexuality was less stigmatized (Shankle et al. 2003). In 1973, the American Psychiatry Association declassified homosexuality as a mental disorder.

During the 1980s' AIDS epidemic, the perception of gay men as deviant and unnatural was reified. Hudson (2011) states:

Due to the perception of being lesbian, gay, bisexual, or transgender, 82 % of these older adults have been victimized at least once in their lives and nearly two-thirds at least three times. More than 66 % have experienced verbal insults; 42 % have been threatened with physical violence; 27 % have been hassled by police; 23 % faced the threat of being outed as LGBT; 22 % were not hired for a job; and 20 % had property damaged. Transgender older adults experience higher levels of victimization and discrimination than non-transgender older adults.

More so than in the past, the twenty-first century ushered in inclusive policies for the LGBT community, including the repeal of "Don't Ask; Don't Tell." Same-sex marriage is now legal across 19 states and the District of Columbia. Eight Native American tribes as well as nine states declare the ban on same-sex marriage as unconstitutional (Freedom to Marry 2013). On June 2, 2014, President Obama declared that gender confirmation surgery could be reviewed for possible Medicare coverage.

Policy Box: On June 2, 2014, President Obama declared that gender confirmation surgery could be reviewed by Medicare for coverage <http://www.hhs.gov/dab/decisions/dabdecisions/dab2576.pdf>.

Despite these important legal advancements, LGBT older adults face social isolation, high rates of suicidality, and depression. Among LGBT older adults, 59 % feel lonely and lack companionship, and 53 % feel isolated from others (Fredriksen-Goldsen et al. 2011). Recent research shows that lesbians, gay men, and bisexuals who have experienced prejudice-related life events were about three times more likely to have suffered a serious physical health problem over a one-year follow-up period compared to those who had not experienced such stressful events (Frost et al. 2011). The effects of prejudice-related events remain statistically significant after controlling for the experience of other stressful events and other factors known to affect physical health, such as age, gender, employment, and lifetime health history. Older LGBT adults have a lifetime of prejudice-related events as a function of living in a society that has struggled with extending equality to all people.

The Grand Master Status of Skin Color

Research is scarce on older adults of color who are LGBT. As a social construction, race is based on phenotype (i.e., hair, skin color, facial features). These variables do not accurately reflect one's race but rather represent a basis for assigning people to a particular racial group (Robinson-Wood 2013). Racism renders an explanation for why LGBT people of color are vulnerable to experiencing the worst outcomes and receiving the least institutional attention.

The aging concerns of LGBT older adults of color are virtually absent in national policy discussions on aging, health, and economic security (Auldridge and Espinoza 2013). LGBT older adults who are also people of color contend with racism and homophobia, which increases levels of psychological distress. Fredriksen-Goldsen et al. (2011) reported that Hispanic and Native American LGBT older adults are more likely to

experience victimization than white LGBT older adults. She also reported that both Hispanic and Native American LGBT older adult participants report lower levels of general mental health, higher rates of depression, and more stress than do whites. The likelihood of neglect for Hispanic and black LGBT older adults is also greater. Compared to whites, Native Americans are more likely to experience anxiety, suicidal ideation, and loneliness. Asian/Pacific Islanders do not differ on mental health indicators from whites with one exception; Asian/Pacific Islanders have lower rates of suicidal ideation. The Center for Black Equity has hosted black LGBT Prides for years in an effort to grant LGBT people of color a separate voice outside of the mainstream LGBT community. Please visit the Center for Black Equity (<http://centerforblackequity.org/>) for more information on how this organization promotes social justice for black LGBT communities.

Some people of color understand the LGBT movement as complicit with an imperialistic culture in support of white superiority. A history of excluding some sexual, gender, and racial minorities influenced some people of color not to identify as LGBT but rather endorse other identifiers (e.g., third gender, down low, MSM, WSW, same gender-loving). Previous studies found that black men having sex with men (MSM) are generally less likely to self-identify as being “gay” when compared to white men, even when they are open about their sexuality (Han et al. 2014). Han et al. (2014) also found that black MSM do not identify as gay because of their marginalization in the larger gay community. Some black MSM men have come to reject what they perceive to be a narrow and non-inclusive definition of sexual relations with other men. Very little research has been conducted on marginalization among LGBT people of color in general and the trans* community of color in particular.

Racism is undeniable in the marginalization of far too many LGBT older adults of color. Research suggests that black and Latino elders experience poverty at twice the rate of the general US elder population. For LGBT elders,

including many of color, a lifetime of employment discrimination translates into earning disparities, reduced lifelong earnings, smaller social security payments, and fewer opportunities to accumulate large pensions and retirement packages (Auldridge and Espinoza 2013).

Patriarchy and racism have contributed to the institutionalization of privilege for some and to disadvantage for others. Although context and situation are relevant, race occupies grand master status in that race has enormous power to eclipse other identities, such as socioeconomic class, professional dress, and title/position (Robinson-Wood 2013). LGBT older adults of color occupy multiple marginalized identities within a system where the grand master status of race is active with respect to one’s position in society, experiences with discrimination, and overall treatment. Irrespective of gender and sexuality, elderly African Americans are more than three times as likely as elderly Caucasians to live in poverty, while elderly Hispanics are more likely than the older population to be poor and in need of long-term care. Elderly women also are highly vulnerable. Nearly three out of four older Americans who fall below the poverty line are women, and retirement incomes for older women average about 55 % of those for comparable men (SAGE 2010).

Internalized homophobia and transphobia exist among some LGBT people of color. Black men experience higher levels of internalized homophobia and are less likely to disclose their homosexual orientation. They are also more likely to perceive their friends and neighbors as disapproving of homosexuality (Graham 2011). In both the Latino and Asian American communities, cultural expectations surrounding family role obligations encourage the maintenance of strong ties to families of origin.

Discussion Box: Concerns about individual behavior that is outside of cultural dictates and subsequent implications for a family’s honor or social standing can weigh heavily on groups characterized by a

collectivistic orientation. How has individualism or collectivism shaped your prescribed identities?

Cultural collectivism may discourage individuation that is commonly seen and necessary to the “coming out” process (Cochran et al. 2007). These cultural expectations may also cultivate internalized homophobia and transphobia experienced by some LGBT older adults.

LGBT Elder Policies in a Young, White, Rich, Straight, Valuing Culture

Half of Americans living with HIV will be over the age of 50 by 2015, and over 80 % of people with HIV are people of color (Hudson 2011). The National Hispanic Council on Aging (2013) recently released a report stating that HIV/AIDS disproportionately affects older gay men. Despite these disturbing data, HIV prevention programs targeted at older adults are virtually nonexistent. Doctors and other healthcare providers avoid talking with their older patients about HIV/AIDS risks (SAGE 2010; Davis 2013). Many healthcare providers endorse the belief that LGBT older adults are not sexually active or are not included in their patient database (National Resource Center on LGBT Aging 2013). Failure to provide adequate care to LGBT individuals is the unfortunate result.

Access to health insurance and to culturally competent healthcare providers is vital to LGBT older adults. That said, LGBT older adults use health care less often than their heterosexual counterparts (Graham 2011). LGBT individuals face stigma from the larger society and also at the physician’s office. LGBT individuals face discrimination in the healthcare system that can lead to difficulty obtaining care, denial of care, or to the delivery of inadequate care (Graham 2011). The National Resource Center on LGBT Aging (2013) outlined a few misconceptions often heard from healthcare providers: (1) We do not have any

LGBT older adult clients; (2) I can identify the LGBT individuals within my service population; (3) I treat everyone as equal; (4) there is not a distinction between gender and sexual identity; and (5) it is illegal to ask about a person’s sexual orientation or gender identity. Healthcare providers’ inability to recognize differences between the LGBT older population and the heterosexual population can be costly to LGBT older adults whose histories include an active substance abuse or chronic illness such as HIV/AIDS and/or depression. For trans* individuals, hormones must be monitored and adjusted as people age (Fredriksen-Goldsen et al. 2014).

Research Box: As individuals age, it is important for doctors to monitor trans* individuals’ hormones and adjust testosterone and estrogen levels as they fluctuate with age. Estrogen and testosterone can have effects on menopause, osteoporosis, hair loss, weight distribution, and ovarian and breast cancer as adult age. See <http://transhealth.ucsf.edu/trans?page=protocol-aging> for more information. How do hormones play a role in trans* individuals’ life? Are medical intake forms asking broad enough questions to understand possible medical issues that trans* individuals may face? How do black market hormones play a role in medical care?

In long-term care facilities where LGBT older adults are at their most vulnerable stage, discrimination endures. A recent national report with LGBT older adults found that more than half of the survey’s respondents believed that staff or other residents would abuse or neglect an LGBT elder. The same study revealed that respondents reported a disproportionate amount of mistreatment in long-term care facilities out of fear of and hatred toward LGBT people, even among those who are elderly (Auldridge and Espinoza 2013). Many LGBT older adults continue to be forced into the closet and are forbidden to make essential choices about and for

their partners. Because, in most cases, LGBT couples are not legally recognized, hospital visitation policies may exclude same-sex partners or other family members, which can impede or complicate critical health decision-making processes (Grant et al. 2010a). Although President Obama issued a memorandum (House 2010) allowing for LGBT couples to make decisions for each other, many hospitals and long-term care agencies refuse to follow suit.

Another challenge for LGBT older adults is financial insecurity as they enter retirement. Overall, 42 % of all LGBT elders indicated that “financial problems” are a big concern in their lives (SAGE 2010). Many LGBT individuals have faced historical employment discrimination that has resulted in lower levels of financial security throughout life and that directly affects retirement income and social security payouts. A recent article by *New York Times* economists Tara Siegel Bernard and Ron Lieber estimated the added costs incurred by a hypothetical same-sex couple between \$41,196 and \$467,562 (Grant et al. 2010a). The poverty rate for senior gay couples is 5 and 9 % for lesbian couples (SAGE 2010). Trans* individuals are more likely to live in extreme poverty and are nearly four times more likely to have a household income of less than \$10,000/year as compared to the general population (Grant et al. 2010b). Employment discrimination against trans* individuals is rampant; 90 % of those surveyed reported harassment, mistreatment, or discrimination (Grant et al. 2010b) with no legal protection because the Employment Non-Discrimination Act (ENDA) has not passed through Congress yet. With the repeal of the Defense of Marriage Act (DOMA), LGBT older adults are able to receive retirement benefits, social security, benefits for military action, and Medicaid after their spouse is deceased. This important legislation does not alleviate the lost financial opportunities for LGBT older adults whose partners died prior to DOMA.

Recently, the US Department of Housing and Development (HUD) (Friedman et al. 2013) released a study about housing discrimination toward individuals who identify as LGBT. HUD (Friedman et al. 2013) concluded that gross

estimates of discrimination, which reflect the extent to which heterosexual couples were consistently favored over gay male or lesbian couples, are 15.9 and 15.6 %, respectively. Sexual orientation and gender identity are not federally protected classes. In efforts to end housing discrimination against LGBT individuals, on February 3, 2012, HUD published its Final Rule, “Equal Access to Housing in HUD Programs regardless of Sexual Orientation or Gender Identity.” This ruling prohibits HUD-assisted organizations from discriminating on the basis of sexuality or gender identity. There is very little recourse for LGBT individuals when other organizations continue to discriminate, particularly with laws written as they are.

Contending with financial insecurities, housing, and other types of chronic discrimination is a breeding ground for social isolation and depression. LGBT older adults may be denied housing, including residency in mainstream retirement communities, based on their sexual orientation, gender identity, and expression. This discrimination may separate LGBT older adults from beloved friends or partners or push them into homelessness (SAGE 2010). In response to systemic housing discrimination, some LGBT older adults have created non-mainstream retirement communities that honor diversity. LGBT older adults have even been able to erect small retirement communities and assisted living communities. For resources and advocacy groups, please visit these Web sites for more information (Legal Resources: <http://www.lambdalegal.org/> and <http://www.hrc.org/resources/entry/maps-of-state-laws-policies>).

Research Box: Research shows that the rate of homelessness among elders has increased in the last decade with about 2,960,000 elder adults who are homeless. Rates for LGBT older adults homelessness are currently not recorded, but 30 % of LGB older adult couples faced housing discrimination and 19 % of trans* older adults being denied a home or an apartment.

Policy Impact and Mental Health for LGBT Older Adults

As individuals transition into older adulthood, multiple challenges arise, such as disability and loss of loved ones. Compared to their heterosexual counterparts, lesbian, gay, and bisexual older adults are at an elevated risk of disability and psychological distress (Hudson 2011). A 2006 study reported evidence of higher levels of depression and psychological distress among midlife and older lesbians and gay men, which the researchers attribute to the accumulated effect of a lifetime of stigma (SAGE 2010).

Defined as chronic stress related to stigmatization and actual experiences of discrimination and violence, minority stress has been found to increase loneliness in LGBT older adults (SAGE 2010). An alarming 41 % (out of 6450 individuals) of trans* older respondents reported attempting suicide compared to 1.6 % in the general population (Grant et al. 2010a). In an effort to address disparities, former Secretary Kathleen Sebelius of the US Department of Health and Human Services (HHS) announced on June 29, 2011, that HHS would begin collecting data through population health surveys to facilitate identification of health issues (National Resource Center on LGBT Aging 2013).

In light of the mental health disparities between heterosexual and LGBT older adults, there is a distinction between health policies that perpetuate marginalization and policies that protect human rights. Policy differences between state and federal governments are a hindrance to having full protection under federal mandates. Medicaid now offers benefits to legally married same-sex couples. Prior to 2014, this was not the case. Thousands of people have access to healthcare providers. The Institute of Medicine (IOM) defines access to health care as the “timely use of personal health services to achieve the best possible outcomes.” With the passage of the Affordable Care Act (ACA), LGBT older adults will have health insurance previously unavailable. Moreover, the ACA has created an insurance-based system that allows LGBT

individuals access to healthcare plans targeted for same-sex families and trans* individuals. Unfortunately, homophobia and multicultural incompetence from healthcare professionals have contributed to primary care underutilization for many LGBT individuals (Grant et al. 2010a).

The Federal Family Caregivers Support Program, which was created with the 2000 reauthorization of the Older Americans Act and amended in 2006, expanded its definition of family caregivers to include extended LGBT family members (Grant et al. 2010a). This program provides LGBT individuals who are caregivers to partners or family members by choice with the ability to utilize respite care, counseling, support groups, and training groups. This bill is significant for many reasons. First, it reflects social justice and basic human rights. Second, when the data are examined, it is evident that LGBT individuals are more likely than are heterosexuals to report a disability: 41 % aged 50 and older report a disability (Hudson 2011).

The Family Caregivers Support Program broadened the definition of families in 2006. In 2013, with the repeal of the Defense of Marriage Act (DOMA), individuals were protected by the Family Medical Leave Act (FMLA). FMLA allows people to take extended periods of paid leave to care for their partners (United States Department of Labor 2013). Family of choice is critical for caregiving given the substantial numbers of LGBT older adults receiving support from families of choice or partners; 27 % provide assistance to someone close to them with a health issue. A national survey of LGBT baby boomers by the MetLife Mature Market Institute found that 42 % of LGBT caregivers reported assisting partners, friends, neighbors, or others outside of their families of origin. Another recent study found 32 % of gay men and lesbians providing some sort of informal caregiving; 61 % of their care recipients were friends, and 13 % were partners (Grant et al. 2010a). There is a limited research on trans* individuals with respect to family of choice and caregiving. The National Center for Transgender Equality (Grant et al. 2010b) stated that 55 % of respondents

experienced family rejection; 45 % of respondents reported that their family is as strong today as it was before coming out.

Case Study

In the case study of Ginger, we see a common story that is told among transwomen veterans. Pay close attention to the intersections of gender, race, age, religion, employment, and substance use in Ginger's life.

Ginger was born male. For as long as Ginger could remember, being male felt like a mistake. Ginger had a military career for over three decades. Once Ginger left the military, she went to culinary school and worked as a chef for ten years. Ginger is now retired. For the last two years, Ginger's outward appearance has been feminine with respect to appearance, hairstyle, makeup, dress, and mannerism. Ginger identified as a male for 60 years but did not identify as gay in her attraction to men. For her 65 birthday, Ginger's gift to herself is gender-confirming/reassignment surgery. Ginger's youngest sister is present to support Ginger before and after the surgery. Raised in a very devout Catholic, Puerto Rican family that vehemently denounced Ginger's interest in girls' toys and clothes, Ginger could not reconcile being openly transgender with her family. Out of respect for her parents' feelings and reputation, her plan was to come out after both her parents died. At the age of 60, Ginger decided the wait was over. Both her parents are in their late 80s and enjoy good health. Ginger is determined to live the remaining years of her life as authentically and honestly as possible. Married to a woman for 16 years, Ginger fathered three children who are now adults in their 40s. Her children have limited contact largely due to Ginger's emotional unavailability to them and her history of addiction. Ginger credits her sanity to a good therapist whom she has seen for three years. In therapy, Ginger learned that she was dying as she waited for her parents to die. She also came to realize that respect was not driving her decision to come out after her parents' deaths but fear,

deception, and shame. Therapy also helped Ginger think about what it means to be an older transsexual woman of color. Throughout her life, Ginger battled not only heterosexism but also racism, sexism, internalized self-hatred, and ageism. She also struggled with alcoholism but has been sober for eight years with the help of Alcoholics Anonymous. Therapy provided a space for Ginger to declare that she was a transfemale who has always been and is currently attracted to men. Her decision to undergo surgery was not attached to the presence of a life partner, although finding a loving relationship with a man is something that Ginger desires. She has found dating to be challenging, especially as she ages. Once Ginger came out as a transgender, Ginger's parents ceased communication, claiming that Manuel (Ginger's birth name) is dead to them.

Self-Check Exercise: Pair and share with another student in the classroom. Discuss your feelings about Ginger. How do you feel about her decision to marry when she knew she was queer? What are your feelings about Ginger's surgery at age 60? How do socially constructed notions of beauty, age, and sexuality collide for Ginger and/or impact your feelings about her life choices?

Discussion of Case Study

Trans* individuals may be less likely to disclose their sexuality than their heterosexual counterparts. Ginger resisted the asexualization of her sexuality by disclosing her sexuality and stepping into her life as the female that she knew she was. Disclosure of sexual and gender identity can lead to an array of social and community support in the LGBT community (Fredriksen-Goldsen et al. 2011). Mental healthcare providers are encouraged to be familiar with community resources. Knowledge of sexual identity development models (e.g., Cass 1979 and Troiden

1989) can assist the clinician in understanding phases and junctures of development, from fragmentation to affirmation (Robinson-Wood 2013). Ginger's therapist needs knowledge of the historical implications of homophobia and transphobia on transgender individuals, medical care concerns, particularly given Ginger's recent surgery and continued hormone use, and aspects of LGBT culture for older transwomen.

Hardacker et al. (2013) and the Howard Brown Health Center (HBHC) developed the nurses' Health Education About LGBT Elders (HEALE) curriculum, a 6-h cultural competency curriculum that focuses on providing training for nurses and other direct caregivers (for more information, visit <http://www.nursesheale.org/curriculum/>). Individuals who have been trained using the HEALE modules have shown increase in health care providers' confidence in administering culturally sensitive care to older LGBT individuals. There are six modules that would be helpful for Ginger's medical team to review: (1) introduction to the LGBT elder community; (2) barriers to health care and health disparity; (3) sex and sexuality of LGBT elders; (4) legal concerns for LGBT elders; (5) an introduction to transgender community; and (6) human immunodeficiency virus (HIV) and aging (Hardacker et al. 2013).

Interprofessional collaborations are needed to provide the best care for Ginger. A multipronged approach would encompass nursing, geriatric medicine, and psychosocial education. Ginger's multiculturally competent therapist needs the ability to create a holding environment for Ginger's excitement, fear, anger, and shame while facilitating the acquisition of skills needed to be healthy and whole as a transwoman of color in a society that struggles with extending justice and decency for Ginger and others like her.

Summary

LGBT older adults have faced a lifetime of discrimination yet continue to fight for equality and resist homophobia and ageism. A 63-year-old

gay man quoted in The Aging Health Report (Fredriksen-Goldsen et al. 2011) said, "The LGBT community has stepped up in the past to address coming out, AIDS, and civil rights. The next wave has to be aging." LGBT older adults have a distinct experience of aging stemming from shared experiences in relation to the LGBT community, the lifelong process of coming out, the experience of sexual and gender minority stress, marginalization inside and outside LGBT communities, and LGBT pride and resilience (Van Wagenen et al. 2013).

LGBT older adults have created families of choice when biological family is physically removed or emotionally detached. Family of choice is one way that older LGBT adults thrive and alleviate isolation and depression. In many ways, the LGBT older adult community shows resilience (Fredriksen-Goldsen et al. 2011) and the ability to handle adversity and challenges successfully, which are important keys to maintaining good physical, social, and mental health. Meyer et al. (2011) found that participants spoke of the positive aspects of exposure to stigmatizing experiences. Some who identify as a LGBT individual, and for some, persons of color and women, felt like they were *better people* for surviving and thriving in the midst of oppression. It is possible that some LGBT older adults may be in a better position to age successfully compared to their heterosexual counterparts because some older LGBT adults have acquired strengths, including adaptability, self-reliance, advocacy skills, crisis competencies, and gender role flexibility (Hash and Rogers 2013).

Discussion Box

1. What are issues experienced by trans* individuals that may differ from those experienced by gay men or lesbians?
2. Is there a relationship between cumulative and multiple oppressions (racism, heterosexism, transphobia, ageism) and Ginger's addiction to alcohol?

3. What are the health implications of surgery and hormones at Ginger's age and as she continues to age?
4. Although sexual orientation is unlikely to change (APA 2009), some persons modify their identity (e.g., change their reference group or self-label behavior). What was the impact on Ginger in her early years when trying to deny her sexual and gender identities?

- c. Those with gender reassignment
- d. None of the above
2. Individuals who have gender-conforming identities where biological sex and gender match are referred to as:
 - a. Bisexual
 - b. Transgender
 - c. Cisgender
 - d. Questioning
3. Which of these is an instance of homophobia and elder abuse?
 - a. An individual says that a woman with short hair looks like a man.
 - b. An older gentleman is visiting his partner in a nursing home, a nurse enters the room and says please leave visitation rights are only for family members only.
 - c. A grocery store bagger helps carry out an older woman's bags to her car.
 - d. A doctor forgetting to ask about an older individual's sexual behaviors.
4. What are older LGBT individuals more at risk of developing than the older heterosexual population?
 - a. More friendships
 - b. Arthritis
 - c. Dementia
 - d. Depression
5. What are discourses?
 - a. Ways of constituting knowledge, together with the social practices, forms of subjectivity.
 - b. Power relations that inhere in such knowledge and relations between them.
 - c. Practices based on knowledge
 - d. a and b

Experiential Exercises (3)

1. Draw four stick figures on the board and label them each as follows: sex, gender, sexual attraction, and sexual behaviors. As a group, have people draw what each of these four categories mean on the stick figures. After you are finished, discuss identities and how they intersect.
2. Create a character that embodies several of the identities in the chapter (older adult, LGB, trans*, and person of color). Have each individual partner up and role-play a scene that would be common in their profession (counselor, nurse, social worker). Ask each pair of individuals to discuss challenges in the conversation.
3. Watch "Gen Silent" and discuss how loss, health, sexuality, gender, and family play important roles in people's lives as they age.

Multiple-Choice Questions (5)

1. Based on the social stratification of gender, which of the following groups benefit from privilege among LGBT populations?
 - a. Those born as female
 - b. Those born as male

Key

- 1-b
- 2-c
- 3-b
- 4-d
- 5-d

Resources

- A Report of the National Transgender Discrimination Survey: <http://endtransdiscrimination.org/>.
- Lambda Legal: www.lambdalegal.org/.
- National Center for Lesbian Rights: <http://www.nclrights.org/>.
- National Center for Transgender Equality: <http://transequality.org/>.
- National Gay and Lesbian Task Force: <http://www.thetaskforce.org/>.
- National Resource Center on LGBT Aging: <http://lgbtagingcenter.org/>.
- Nurses HEALE Curriculum: <http://www.nursesheale.org/curriculum/>.

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