Sexual Minority Status and Aging

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Abstract

There are estimated to be between 1.4 and 3.8 million LGBT Americans over the age of 65. This population is expected to increase between 3.6 and 7.2 million due to the Baby Boom generation. The older adult population is the most rapidly growing age group in the United States and experiences normal age-related changes in cognition as well as in internal and external physical health. Although differences exist within and among groups, more minority elders live in more poverty and with lower incomes than their white counterparts. Emerging scholarship reveals that social isolation and discrimination experienced by many LGBT elders hinder them from aging well. Increasing diversity of the LGBT elder population has important implications for bolstering individual autonomy in the care environments.

Keywords

LGBT · Demographic characteristics · Theories of aging · Population

Overview

Older adults as a population are living longer than ever before in history. Because of this phenomenon, one relatively recent in history, our understanding of the population of older adults is becoming more nuanced as the once and parochially assumed homogeneity of older adults is disentangled to reveal a landscape that is increasingly heterogeneous. Scholars are increasingly examining the heterogeneity of the older adult population that identifies as LGBT. To that end,

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this chapter delineates an understanding of LGBT elders by providing information on a general aging population as well as on those elders who identify as being in a minority status, particularly those with a sexual minority status. We consider basic age-related changes as well as what they may mean for elders who are LGBT, and we consider current trends and future issues (e.g., health disparities and person-centered care).

Learning Objectives

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

1. Identify basic terms, including sexual orientation and gender identity, LGBT, unisex, queer, questioning, ally, sex, gender role, and gender expressing.
2. Understand relevant characteristics of African-American, Hispanic, and Asian elders.
3. Identify age-related changes.
4. Explain the nexus between aging and LGBT older adults.
5. Describe basic theories of aging salient for LGBT older adults.

Introduction

That older adults are living to longer ages are now culturally and historically accepted, but thinking beyond the fact that older adults comprise approximately a fifth of the US population still seem enigmatic to many. Though many policies and services dating back from the 1960s have evolved to reflect a more nuanced view of the population of adults who are age 65 and over, others have lagged behind, still regarding older adults as a homogenous group. In fact, nothing could be further from the truth. Our understanding of the current population of older adults tends to reveal great differences in race and ethnicity, which is further revealed in sexual orientation and gender identify, education, income, and physical and mental health measures. The population of elders who identify as lesbian, gay, bisexual, and transgender has come to the forefront as our understanding of the aging population becomes more nuanced than in previous generations and as individuals who are aging are coming out more than in previous generations. Legislative landmarks, such as the Defense of Marriage Act (DOMO 1996) and the ensuing state by state legislative and legal battles, heighten the overall awareness and need to understand both how individuals in the general population age as well as how those who are of sexual minority status age.

The purpose of this chapter is to help the reader understand the nexus of sexual minority status and aging. First, we provide definitions germane to those who identify as being members in the population with sexual minority status. Second, we characterize the population of elders, elders with a minority status, and the population of LGBT elders. Third, we explain age-related changes for the general population. Next, we discuss issues of aging for those in a sexual minority status. We explain theories of aging that are salient for the aging population and conclude with a discussion of future considerations for those who are aging and identify as LGBT.

Definitions

The nomenclature surrounding sexual orientation and gender identity, across the life span, is ever-expanding and increasingly complex. The decade between the Stonewall Riots in New York in 1969 and the Castro Riots in San Francisco in 1979 saw an emergence of the term "gay" to replace the largely derogatory term, "homosexual." Both terms served as an umbrella for "gay" men and women. At the same time, as gay women forged more public identities in conjunction with the second feminist movement for equal rights in the 1970s, the terms "gay and lesbian" emerged (Faderman 1991). The terms "bisexual" and "transgender" subsequently emerged also, as new and unique communities

struggled for voice and identity from the macrostructural and overly inclusive "homosexual" umbrella.

Toward the latter part of the 1980s, the initials LGBT and GLBT evolved as inclusive of the lesbian, gay, bisexual, and transgender community in place of "gay" or "gay and lesbian." It is, however, important to note that significant strains of resistance to the inclusivity were present and remain, particularly among bisexual and transgender communities (Alexander and Yescavage 2004). These strains of resistance continue as the LGBT initials expand to include queer, questioning, unisex, intersex, asexual, and ally.

To enjoy a comprehensive understanding of the totality of the sexual orientation and gender identity umbrella of terms requires a nuanced understanding when engaging in a true person-centered approach to care for elders. For the purposes of this and the following chapters, it is important to understand that sexual orientation (LGB) and gender identity (T) are unique. Sexual orientation refers to one's sexual or romantic attraction and, in the case of LGB, refers to a sexual or romantic attraction to members of the same gender. Gender identity refers to someone's innate, psychological (not necessarily physical) identification as male, female, or other gender (see definitions for LGBTQUIA in Fig. 2.1).

Describing the Population

According to the National Gay and Lesbian Task Force (2011), there are currently between 1.4 and 3.8 million LGBT Americans over the age of 65. By 2030, this number is expected to increase to between 3.6 and 7.2 million LGBT Americans, as the Baby Boom population, those born between 1946 and 1964, ages. Although there is no definitive measure to determine the percentage of LGBT individuals in the USA, national organizations such as the Human Rights Campaign and the National Gay and Lesbian Task Force use 3.5 % as a measure.

Certainly, numerous limitations impact the LGBT census, not the least of which are individuals who do not recognize and report their sexual orientation or gender identity. Further, there are those whom the LGBT umbrella does not cover, such as persons who identify as unisex, intersex, and asexual. In addition, the Human Rights Campaign believes that the data based on the 2010 US Census do not represent a comprehensive picture, as the Census only counts individuals from gay- and lesbian-identified households (Gendron et al. 2013). Much of the data on LGBT individuals are aggregated from national, urban studies, many of which do not include older adults; individuals from rural communities; and those who do not, or have not as yet, identified as LGBT. This representation is only one component, however, of those individuals who are considered to be older adults.

Understanding the Older Adult Population

The very description of an older adult calls into question at what age one becomes an older adult. Historians have long recognized that persons as young as age 40 could be characterized as old as late as the early 1900s; the Age Discrimination in Employment Act (1967) covered discrimination of employees aged 40 and over. What does seem to be clear is that most people think of themselves as being "younger than" another person rather than "older than." This statement illustrates that being older is somewhat subjective as well as dependent on the population under examination. For example, the age at which a farmer is considered old is 50 (Amshoff and Reed 2005), which is also the age that HIV/AIDS researchers place research participants in the older adult category (Goodroad 2003). Despite numerous subgroups within the population, many of whom age differently, the age at which recipients qualified for full Social Security benefits was set at age 65 in 1935. In the 1960s, the US government again de facto established old age as being 65 years old or the age when most persons qualify for Older Americans Act, Medicare, and Medicaid dollars and services. These rough age delineations do little to encapsulate what it means to be an older adult who is

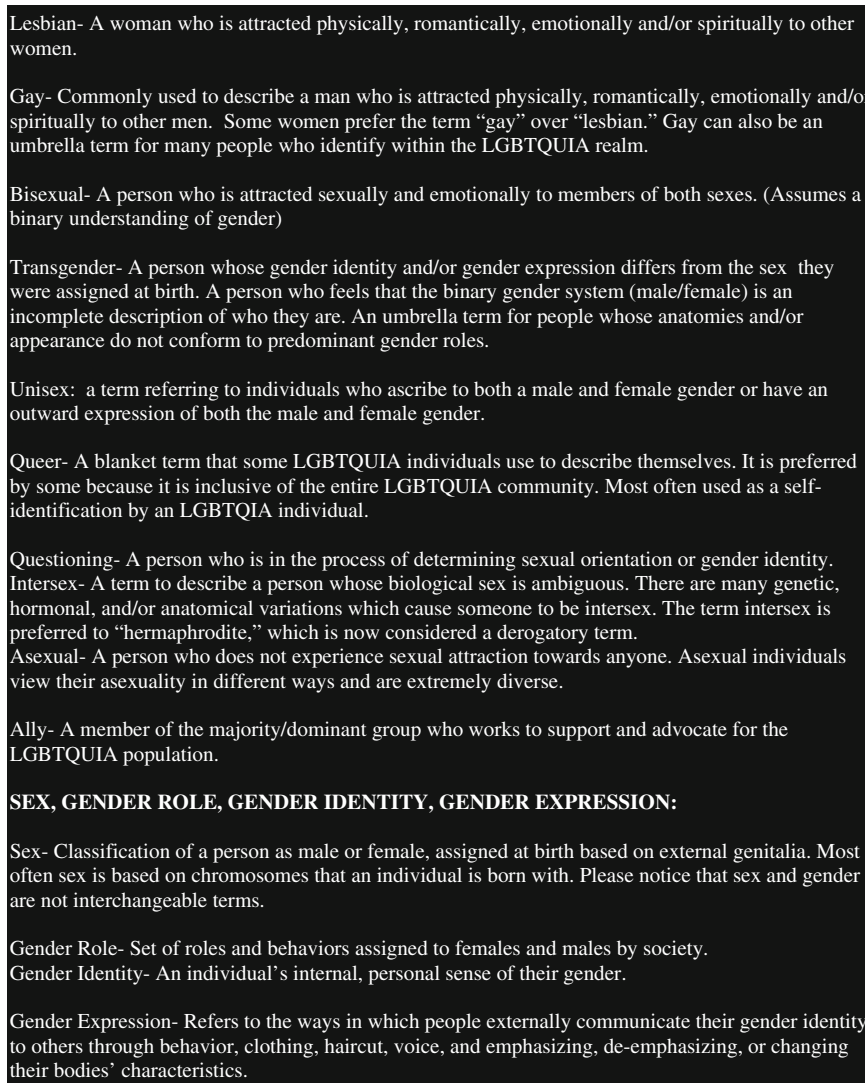

Fig. 2.1 LGBTQUIA alphabet soup (adapted from St. Mary's College Intercultural Lounge)

not a member of the majority group of older adults (at this point, Caucasian), the face of which is rapidly changing (see, especially, Chaps. 6–10). The focus of this chapter is to consider older persons with a minority status, and in many cases, more than one.

In order to understand what it means to be a person in a minority status as well as a person in a sexual minority status, we characterize the older adult population and older adult LGBT population and then present a brief discussion of normal age-related changes that many, but not all persons experience. The population of older adults represents the most rapidly growing age group in the US. For example, in 1990, older adults composed 13 % of the total population. By 2020, that number is estimated to increase to 18 % and to 25 % in 2050 (McKinney and Young 1985). In 2012, persons aged 65+ numbered 43.1 million, for an increase of 21 % since 2002, a number is projected to grow to 79.7 million by 2040. Moreover, the 85+ population, the most rapidly growing age cohort, is projected to increase from 5.9 million in 2012 to 14.1 million in 2040.

Consequently, approximately one in every seven persons in the USA is an older adult: people aged 65+ represented 12.4 % of the population in the year 2000, a percentage projected to increase to 19 % by 2030 (West et al. 2014).

Persons who reach age 65 are projected to have an average life expectancy of an additional 19.2 years (20.4 years for females and 17.8 years for males). Because of their ability to live to longer, older women outnumber older men (24.3 to 18.8 million). Another reflection of that phenomenon is that in 2013, 36 % of older women were widows (Administration on Aging 2010). Also, older men are married far more frequently than are older women (i.e., 71 % of men vs. 45 % of women). About 28 % (12.1 million) of older persons live alone (8.4 million women and 3.7 million men); 45 % of women age 75+ live alone. In 2012, approximately 518,000 grandparents aged 65 or older assumed primary responsibility for their grandchildren who were living with them. In 2012, the median income of older persons was $27,612 for males and $16,040 for females, approximately 9.1 % of those persons were living below the poverty level (Administration on Aging 2010).

Within the older adult population are older adults who are LGBT. Mentioned in Chap. 1 and throughout this book, no accurate percentages of LGBT people in the US exist; however, most researchers estimate that approximately 3–7 % of the aging population are LGBT, most of whom identify as lesbians and gay men. Thus, between one and 3.5 million older lesbians and gay men, this number is expected to double by 2030 (Jackson et al. 2009). Individuals who are aging, those who are heterosexual and those who are LGBT, can expect to experience some age-related changes, typically starting around the fourth decade.

Age-Related Changes that May Affect Older Adults

Cognitive Changes. Changes in our understanding of the aging brain are among the most exciting in all of aging science. Though many adults worry about becoming more forgetful and worry that it is the first sign of Alzheimer's Disease (AD), according to NIH Medline Plus (2007), scientists now know that people can remain both alert and able as they age, although it may take them longer to process their memories. The cognitive functions that aging affects most are attention and memory, which are not simultaneously affected—some aspects are relatively unaffected, while others may decline precipitously. Though the results of studies of psychometric testing of persons of older ages seem to paint a picture of overall cognitive decline, enormous variability exists across aging individuals. Many older people out-perform young people, at least on some cognitive tasks, and others of the same age do at least as well as their younger counterparts (Glisky 2007).

Internal Age-Related Changes. Internal changes occur as adults age. Although many changes occur gradually across an individual's lifetime, the rate is dependent on heredity as well as environment (Rowe and Kahn 1998). Many changes are inter-related; however, the body has a remarkable variety of compensatory abilities that adjust to insults experienced over time. Stressed in previous sections, high variability exists as to when these age-related changes present.

Heart. Age-related changes in heart muscle cells help explain alterations in the heart as a whole. As the heart ages, it thickens, becomes less elastic, and may become enlarged. An older heart is less able to relax completely between beats, and its pumping chambers stiffen. Because the heart is unable to pump as vigorously as it once did, it is less able to supply adequate blood and oxygen to muscles during exercise (Young 2002).

Lungs. Age-related changes to the pulmonary system are associated with structural changes leading to a decline in function. The reduction in the diameter of small airways and their tendency for closing early contributes to air trapping and ventilation problems. With age, the lungs stiffen, making it harder for them expand and contract. The chest wall becomes more rigid, and the diaphragm and other muscles of respiration become

weaker. A decreased cough reflex and a reduction in the number of cilia that sweep mucous up and out of the lungs results in increased likelihood of infection (Medline Plus 2010).

External Physical Changes

Generally accepted physical changes that occur as persons age include a reduction in physical height, usually more pronounced in women than in men (Currey et al. 1996), a decline in total body weight due to a loss of lean body mass, a decrease in bone strength, wrinkling and dryer skin (often exacerbated by exposure to UV rays), and changes in hair color. As with the above, physical changes that older adults experience are subject to great variability. One of the most significant factors thought to slow such changes is physical activity, which is now recommended for in all ages, and in sharp contrast to the prevailing wisdom of the early 1900s, when elder adults were encouraged to rest frequently and preserve their (remaining) strength (Buchner 1997; Roig et al. 2010). Below, we discuss a few examples of common age-related sensory changes.

Sensory Changes. Starting roughly around the fourth decade, eyesight weakens; around the sixth decade, cataracts and macular degeneration may develop for some individuals. Hearing may also decline with age. Mentioned earlier, variability exists within the population of older adults.

Eyesight. Around age 40, most individuals encounter weakened eyesight, and some experience cataracts and glaucoma. Certain adults may be less able to see objects at close distances or read fine print than in earlier years. For most, reading glasses or contact lens address the problem. Other adults are less able to see objects at far distances, and eyeglasses or contact lenses are helpful. Some individuals develop cataracts, which affects nearly 22 million Americans age 40 and older; by age 80, more than half of all Americans have cataracts (National Eye Institute 2008). Corrective surgery is now one of the most common surgeries done in the US. Annual eye examinations can help older adults protect themselves from developing severe eye problems that may occur for some, but not all older adults. Preventive measures (e.g., proper nutrition, wearing sunglasses, and physical activity) can help mollify eye problems that some older adults experience.

Hearing. About one-third of Americans between the ages of 65 and 74 have age-related hearing problems, and about half of adults aged 85 and older have hearing loss (National Institute on Deafness and Other Communication Disorders 2010). Another common problem that some older adults encounter is ringing, roaring, or other noises inside the ears. This problem, known as tinnitus, may be diminished when certain medicines or other health problems (e.g., allergies or atherosclerosis) are addressed.

The central message about age-related changes is that variability exists among older adults. Some adults experience age-related changes so small as to be barely noticeable. Others, however, experience such difficulties that their health and quality of life are greatly diminished. Although some age-related changes do occur over time, there are many opportunities and strategies to mitigate their affects.

Aging and Minority Status

Along with the general trends for America's aging population and the age-related changes described earlier, many minority populations are living to older ages. In this section, we characterize the population of older adults living in a minority status. Below, we focus on older African-Americans, Hispanics, and Asians.

African-American Elders

In 2008, the African-American older population was 3.2 million in 2008 and is projected to grow to over 9.9 million by 2050, when African American elders will compose 11 % of the older population. In 2008, 50 % of black elderly people lived in eight states: New York (9.1 %), Florida (7.1 %), California (6.5 %), Texas

(6.4 %), Georgia (6.1 %), North Carolina (5.5 %), Illinois (5.4 %), and Virginia (4.4 %). In 2008, over 60 % of the black population aged 65 and older had completed high school, as compared with 1970, when only 9 % did so. Also in 2008, over 12 % of black older persons had a bachelor's degree or higher. In 2008, 54 % of older Black men lived with their spouses, 11 % lived with other relatives, 4 % lived with non-relatives, and 30 % lived alone (Fig. 2.2).

For older black women, 25 % lived with their spouses, 32 % lived with other relatives, 2 % lived with non-relatives, and 42 % lived alone. Households containing families headed by black persons aged 65+ reported a median income in 2008 of $35,025. The comparable figure for all older households was $44,188. The median personal income for black men was $19,161 and $12,499 for black women. Comparable figures for all elderly were $25,503 for men and $14,559 for women. The poverty rate in 2008 for black elders (65 and older) was 20 %, or more than twice the rate for all older adults (9.7 %). In 2007, black males had an average life expectancy at age 65 of an additional 15.3 years (to 80.3 years) and black women had a life expectancy of 18.7 additional years (to 83.7 years). These figures are 1.3 years less than the figures for all elderly men and 1.1 years less than the figure for all elderly women. (Administration for Community Living 2010) (see Chap. 7 for a discussion of African-American and LGBT elders).

Hispanic Elders

Making up 6.6 % of older adult, the Hispanic older population numbered 2.5 million in 2007 and is projected to grow to over 17 million by 2050, when they will compose 19.8 % of the older population. By 2019, Hispanic adults aged 65 and older will be the largest racial/ethnic minority in this age group. In 2007, 70 % of Hispanic persons aged 65 and over resided in four states: California (27 %), Texas (19 %), Florida (16 %), and New York (9 %). In 2007, about 42 percent of the Hispanic population aged 65 and older had finished high school, compared with 76 % of the total older population (Administration for Community Living 2010) (Fig. 2.3).

In 2007, 65 % of Hispanic older men lived with their spouses, 17 % lived with other relatives, 3 % lived with non-relatives, and 15 % lived alone. For older Hispanic older women, 39 % lived with their spouses, 33 % lived with other relatives, 2 % lived with non-relatives, and 26 % lived alone. The percent of Hispanic elderly men and women living alone is lower than that of the general population. Also, the percent of Hispanic older persons living with other relatives is nearly twice that of the total older population (Administration for Community Living 2010).

Households containing families headed by Hispanic persons 65+ reported a median income in 2007 of $31,544 (as compared to $43,654 for non-Hispanic Whites). Among such Hispanic

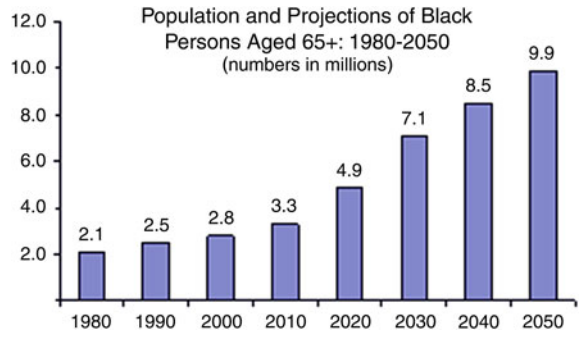

Fig. 2.2 Population and projections for black elders. *Source* Administration for Community Living (2010). A statistical profile of black older Americans aged 65+. Retrieved from http://www.aoa.acl.gov/Aging_Statistics/minority_aging/Facts-on-Black-Elderly-plain_format.aspx

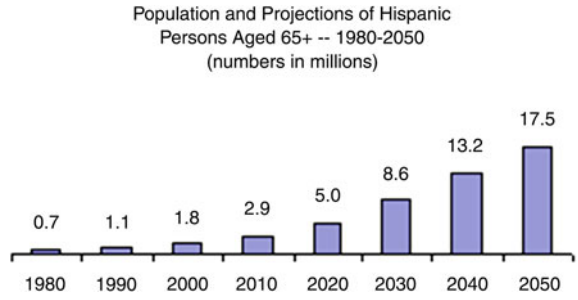

Fig. 2.3 Population and projections for Hispanic elders. *Source* Administration for Community Living (2010). A statistical profile of Hispanic older Americans aged 65+. Retrieved from http://www.aoa.acl.gov/Aging_Statistics/minority_aging/Facts-on-Hispanic-Elderly.aspx

households, 16 % had an income of less than $15,000 (compared to 5.4 % for non-Hispanic Whites family households) and 45 % had incomes of $35,000 or more (compared to 62 % for non-Hispanic Whites). The poverty rate in 2007 for Hispanic older persons (65 and older) was 17.1 %. This was more than twice the percent for non-Hispanic Whites (7.4 %) (Administration for Community Living 2010) (see Chap. 10 for a discussion of Hispanic and LGBT elders).

Asian Elders

Older members of the older adult population who identified as Asian, Hawaiian, and Pacific Islander numbered over 1.3 million in 2008 (3.4 % of the older population) and is projected to grow to over 7.6 million by 2050, at that time accounting for 8.6 % of the older population. In 2008, almost 60 % of Asian, Hawaiian, and Pacific Island elders lived in just three states: California (40.5 %), Hawaii (9.6 %), and New York (9.2 %). In 2008, 74 % of the older Asian population aged 65 and older had finished high school. Also in 2008, almost 32 % of Asian older persons had a bachelor's degree or higher. The percent of high school graduates among older Asians is almost as high as the percent among all older persons (77 %). However, the percent of older Asians in 2008 who had a bachelor's degree or higher (32 %) was over 50 % higher than for the overall older population. Furthermore, the percent of male Asians who had a bachelor's degree or higher (40 %) is almost 50 % higher than for the overall older population (27 %) (Administration for Community Living 2010) (Fig. 2.4).

In 2008, 84 % of older Asian men lived with their spouses, 6 % lived with other relatives, 2 % lived with non-relatives, and 8 % lived alone. For older Asian women, 47 % lived with their spouses, 30 % lived with other relatives, 3 % lived with non-relatives, and 20 % lived alone. Households containing families headed by Asian persons aged 65+ reported a median income in 2008 of $48,859. The comparable figure for all older households was $44,188. The median personal income for Asian men was $18,518 and $11,501 for Asian women. The comparable figures for all elderly were $25,503 for men and $14,559 for women. In 2008, the poverty rate in for Asian elders was 12.1 %; the rate for all elders was 9.7 %. The rate for Asian men was 11.1 %, and the rate for Asian women was 12.8 % (Administration for Community Living 2010) (see Chap. 8 for a discussion of Hispanic and LGBT elders).

The data above posted by the Administration for Community Living and distilled from the information reflected by the US Census indicate that there are both differences and similarities between and among older adults with a minority status and those who are Caucasian. In the main, minority status for elders means that they live in greater poverty and with lower incomes that do those with majority status. For older Asian-Americans, the educational level attained

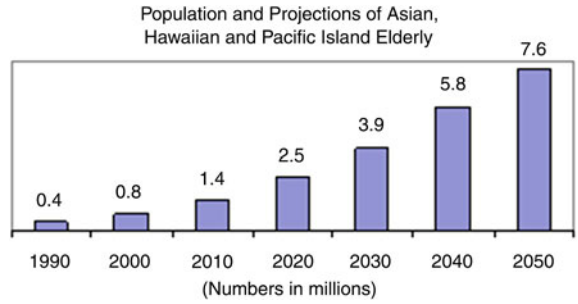

Fig. 2.4 Population and projections for Asian, Hawaiian, and Pacific Island elders. *Source* Administration for Community Living (2010). A statistical profile of Asian older Americans aged 65+. Retrieved from http://www.aoa.acl.gov/Aging_Statistics/minority_aging/Facts-on-API-Elderly2008-plain_format.aspx

is actually higher than that of the general population. All older adults of minority status live with their spouses more so than those of the general population. Also, the older adult population as a whole, whether or not they are members of minority groups, are living longer than were previous generations, a trend continuing until at least 2050. Statistics are but one way to understand what it is like to be a member of a minority population. Another are stressors, affecting both physical and mental health—much has been written on early and persistent stressors over the life course and will not be discussed here. However, one important stressor that will be discussed below are implications for being a member of a minority status and a member of a sexual minority.

Aging and Sexual Minority Status

In recent years, new scholarship has emerged on the barriers to positive aging faced by members of the LGBT population (e.g., Fredriksen-Goldsen et al. 2011). It has taken decades for this information to "come out" simply because it has been difficult to acquire data from this largely unseen and fragmented population. In a 2010 study, the National Resource Center on LGBT Aging reported that there are approximately 1.5 million lesbian, gay, bisexual, and transgender elders currently residing in the USA. Given the increase in the number of Baby Boomers, those born between 1946 and 1964, this number is expected to increase to approximately 3.5 million by 2030. Among these elders, social isolation has been identified as affecting a disproportionate numbers as they continue to deal with stigma, discrimination ageism, homophobia, and transphobia (see Table 2.1).

LGBT Optimal Aging: Barriers and Opportunities

Older reports and other supporting data indicate rates of smoking, alcohol use, and obesity higher for the LGBT population than their heterosexual peers (Hughes and Evans 2003). Also, older data tend to support other antiquated stereotypes of the LGBT population: immersed in a culture of alcoholism, depression, and poor health habits. Examples of real evidence-based qualitative and quantitative studies on LGBT elders began to emerge in the 1990s and 2000s when membership from national organizations including the Human Rights Campaign, National Gay and Lesbian Task Force, and Services and Advocacy for GLBT Elders (SAGE) were queried. Although an improvement, the data were collected from members of the LGBT population who are active, enfranchised, engaged, and more likely to participate in "out and proud" organizations. Many of the previous studies lack statistical power due to small sample size and a high potential for participant bias. Therefore, it is unwise to unilaterally rely on research that is still emerging and calibrating. Although excellent,

Table 2.1 Support systems of LGBT elders and the general elderly population

Support system	LGBT elders (%)	General elder population (%)
Live alone	75	33
No children	90	20
Single	80	40

(Adapted from the Web site of services & advocacy for GLBT elders on social isolation. Retrieved from http://www.sageusa.org/issues/isolation.cfm)

rich, and statistically significant studies have recently been completed (Fredriksen-Goldsen et al. 2011), further research that supports a person-centered model of care and inquiry is needed.

Emerging scholarship tells us that elders who are isolated are at increased risk for abuse and premature death (Acierno et al. 2010; Pantell et al. 2013). Compounding this, according to SAGE, LGBT elders are at increased risk for isolation: LGBT elders are over twice as likely to live alone with thinner support networks, three to four times less likely to have children, and twice as likely to be single as compared to the heterosexual population. LGBT elders have higher disability rates, struggle with economic insecurity, and have increased mental health concerns manifest from a lifetime of discrimination (SAGE 2010).

The Caring and Aging with Pride Study (2011) gives additional information on why the barriers to inclusion and "othering" of LGBT elders are so real and profound. The study found that 82 % reported having been victimized at least once, with 64 % reporting experiencing victimization at least three times in their lives. The report notes: "The most common type of victimization is verbal insults (68 %), followed by threats of physical violence (43 %), and being hassled by the police (27 %). Nearly one in four (23 %) have had an object thrown at them, and one-fifth (20 %) have had their property damaged or destroyed. Nearly one in five (19 %) have been physically assaulted (i.e., punched, kicked, or beaten), 14 % threatened with a weapon, and 11 % have been sexually assaulted."

This discrimination continues into later life. According to a 2005 study of LGBT long-term care residents, LGBT elders fear discrimination from administration, direct care professionals, and other residents (Johnson et al. 2005). These responses varied widely with regard to the variables of age, income, gender, community size, and education level of the respondents but are concurrent with the notion, even among healthcare professionals and, arguably, younger members of the LGBT community, that LGBT elders are "homogeneous, isolated, lonely and without hope." (Johnson et al. p. 86).

According to the National Gay and Lesbian Task Force, the fear of isolation is real among LGBT elders. For many elders who have experienced marginalization and disenfranchisement over the life span, with advancing age comes an increasing reliance on public programs and social services. LGBT elders have less independence or ability to retreat from discrimination, consequently reinforcing isolative behaviors and leading to the negative health outcomes outlined above.

Further, as of this writing, housing discrimination based on sexual orientation and gender identity is prohibited in only 15 states and the District of Columbia: California, Colorado, Connecticut, the District of Columbia, Illinois, Iowa, Hawaii, Maine, Minnesota, New Jersey, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington. There are also six states that prohibit housing discrimination based on sexual orientation (but not gender identity): Delaware, Maryland, Massachusetts, New Hampshire, New York, and Wisconsin. In addition, many cities prohibit discrimination on the basis of sexual orientation, including Atlanta, Chicago, Detroit, Miami, New York, Pittsburgh, and Seattle. While the status of the LGBT population is changing, anti-discrimination is by no means universal.

When reviewed in its sum, there are few "usual and normal" phenomenon facing LGBT elders. Social isolation is a common occurance. Fear of healthcare professionals is a theme that is worthy of note. The lack of family caregivers is also a barrier for positive aging. But when evaluating sexual orientation, gender identity, and aging, there is much more to the story. While discrimination and fear are pervasive in these communities, there are examples of positive aging. In particular, studies by Frederiksen-Golden et al. (2011) and others are revealing the emergence of stronger scaffolding, with stories of resilience in the face of adversity (see Table 2.2).

Theories of Aging as Applied to LGBT Elders

Data discussed above demonstrate that diversity among elders is on the rise from racial, ethnic, sexual orientation, and gender identity perspectives. This is not only true from basic demographic data, but it is also true from gerontological theories that have applicability for the older adult LGBT population.

The Continuity Theory of Aging (Atchley 1989) suggests that, in making adaptive choices, middle-aged and older adults attempt to preserve and maintain existing internal and external structures. They prefer to accomplish this objective by using strategies tied to past experiences of themselves and their social world. Change is linked to the perceived past, producing continuity in inner psychological characteristics as well as in social behavior and in social circumstances. Continuity is thus a grand adaptive strategy that is promoted by both individual preference and social approval. In other words, what makes elders unique earlier in life will only be enhanced in later life, particularly true for LGBT elders?

Another salient theory for aging persons who are LGBT and that draws upon Continuity Theory is Carstensen et al. (2003) Socioemotional Selectivity Theory, which suggests that, with age and the realization of mortality, individuals focus on more personally relevant and meaningful pursuits and passions. As persons age, items that comprise individuality and uniqueness become more pronounced with age. As individuals age, regardless of race, ethnicity, and sexual orientation of gender identity, they tend to focus their attention on a more refined series of activities, experiences, emotions, and memories. Increasing the focus on "things" that make us unique that supports the inherent diversity of the aging population.

Though most research on LGBT elders examines those in community settings, the increasing diversity of the aging population also has profound implications for the long-term care continuum (Fig. 2.5).

One challenge is that the long-term care continuum, from independent living through skilled nursing facilities, has been developed in a medical model. The medical model suggests a top-down approach to direct care that supports uniformity and lack of participation in medical treatment, a model better suited to the generalizations alluded to in the previous section. The medical model ascribes to the philosophy that the dispensation of medication, the creation of

Table 2.2 Risks for elders lacking adequate social interaction

• Older people without adequate social interaction are twice as likely to die prematurely
• This increased risk of mortality is comparable to smoking **15** cigarettes per day, **6** alcoholic beverages per day, and it is twice as dangerous as obesity
• 43 % of elders experience social isolation
• 11.3 million elders live alone (8.1 million are women)
• Based on current demographic trends, 16 million elders will live alone by 2020
• Older adults without adequate social interaction are twice as likely to die prematurely

activities, the development of menus, and, really, the physical structure of the long-term care environment can be created on an assembly line.

Person-centered care is a holistic approach to care that recognizes and empowers the uniqueness of each individual. It supports individual autonomy throughout the long-term care continuum while creating environments conducive to independence, engagement, social confidence, respect, and diversity. (Barsness and White 2011). Scholars, educators, and employees who work in the long-term care continuum are seeing a culture-change movement that supports the redirection of care to a person-centered model. This approach is extremely important for members of the LGBT community because it creates an environment where apathy and even discrimination is unacceptable and where uniqueness is actually embraced.

The person-centered care movement to inform culture change in long-term care is by no means fully accepted by owners of long-term care communities, administrators, direct care professionals and regulators or inspectors. Efforts by organizations such as the Pioneer Network and initiatives such as the Eden Alternative (Thomas 1996) are far from universally acknowledged and integrated into regulations, organizational mission statements, care plans, and direct care practices. The push and pull of profitability versus person-centered care and culture change, to say the least of more historically conservative values and norms, should be considered when evaluating the following chapters.

Summary

The letters LGBT represent an initialism that indicates lesbian, gay, bisexual, and transgender community. National Gay and Lesbian Task Force (2011) reported that there are currently between 1.4 and 3.8 million LGBT Americans over the age of 65, and this population is expected to increase to between 3.6 and 7.2 million due to the Baby Boom generation.

We have discussed the characteristics of the older adult population in order to aid readers' understanding of elders with a sexual minority status. The older adult population is the most rapidly growing age group in the USA with

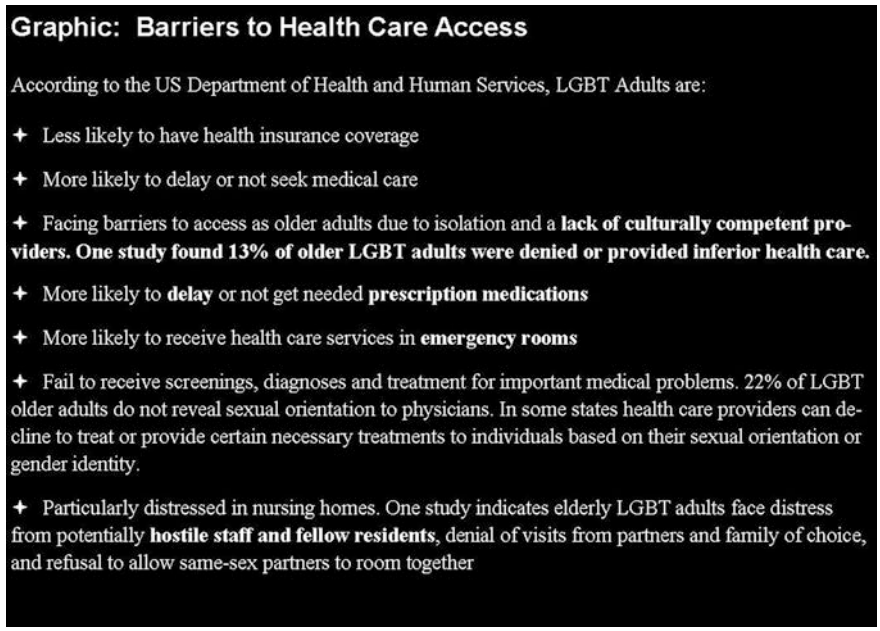

Fig. 2.5 Barriers to health care for LGBT elders. *Source* LGBT—health disparities impacting long-term care. Retrieved from http://longtermcare.gov/the-basics/lgbt/lgbt-health-disparities-impacting-ltc/

extended average life span. Older adults experience normal age-related changes in their cognition and internal and external physical health. Differences and similarities exist in the trends between elders in a minor racial/ethnic group, and those who are Caucasian, but, mainly, minority elders live in more poverty and with lower incomes.

Although scholarly attention to aging of LGBT elders is increasing, much research needs to be done to discover this largely isolated and fragmented population. Nevertheless, emerging scholarship has investigated how social isolation and discrimination experienced by LGBT elders hinder them from achieving positive aging (e.g., Caring and Aging with Pride Study 2011). Also, several gerontological theories have applicability for the LGBT elders including, the Continuity Theory of Aging (Atchley 1989) and the Socio-emotional Selectivity Theory (Carstensen et al. 2003). Increasing diversity of the aging population, especially the LGBT elder population, has important implications for the continuum of long-term care, suggesting the necessity of bolstering individual autonomy in care environments.

Discussion Box 2.1: Barriers to Optimal Aging Encountered by LGBT Elders

Read the article below, "*LGBT Advocate Sees Hurdles Ahead,*" written by Michael Adams, Retrieved from the Web site of AARP: http://www.aarp.org/relationships/family/info-04-2011/biggest-issues-facing-older-lgbt-americans.html.

"America's older population is growing, and so is the number of lesbian, gay, bisexual and transgender (LGBT) adults who are moving into their later years. In the next several decades, LGBT adults age 65 *and above is expected to double, reaching more than* 3 *million by* 2030*. In my job as executive director of SAGE (that's for Services & Advocacy for Gay, Lesbian, Bisexual and Transgender Elders). I'm constantly hearing about the unique challenges facing our community. These are the five main things we need to change if we want our society to be prepared for the full diversity of its aging population*:

1. *Basic Health Care*
   In the United States, about 80 percent of long-term care for older people is provided by family members, such as and spouses, children and other relatives. But LGBT elders are only half as likely as their heterosexual counterparts to have close family to lean on for help. This means that they rely heavily on the services of professional health care providers—doctors, pharmacists, or hospital and nursing home staff—who might be uncomfortable with or even hostile toward LGBT elders and who are not trained to work with them. In SAGE's experience, even when these providers are supportive, fear of discrimination prevents many LGBT older people from seeking out the care they need.
2. *Caregiving Issues*
   Can you imagine not being able to care for a longtime partner or spouse, or have any say in your loved one's medical care? It's unthinkable for most of us. Because the support systems of LGBT elders—their partners and their families of choice—often are not recognized under the law, LGBT people frequently are not granted family or medical leave to take care of a sick or terminally ill partner. Furthermore, LGBT people can be excluded from decision-making on a partner's medical care and funeral plans, unless they have put specific legal arrangements in place. Unfortunately, many people don't make such arrangements, either because they can't afford the legal costs or because they, like so many Americans, think they can put them off for another day. (Here's a link to resources

that can help you get those documents prepared.)

3. *Financial Insecurity*
   LGBT older people are less financially secure than American elders as a whole. For example, poverty rates among elder lesbian and gay couples are 9.1 *and* 4.9 *%, respectively, compared with* 4.6 *% among elder heterosexual couples. Several factors contribute to higher poverty rates, including employment discrimination and barriers in Social Security, Medicaid, and pension and retirement plans that deny same-sex couples key retirement benefits afforded to the broader population. In addition, state laws can shut LGBT partners out of an inheritance, or can require them to pay steep taxes on an estate that a surviving heterosexual spouse would inherit tax-free.*
4. *Social Isolation*
   Despite creating families of choice and other support networks, many LGBT older people still experience high rates of social isolation. They are twice as likely to be single and to live alone, and three to four times as likely to be childless. They are also less likely to feel welcome in the places where many older people socialize, such as senior centers, volunteer centers and places of worship. Research and SAGE's experience show that the harmful effects of this include depression, delayed care-seeking, poor nutrition and premature mortality.
5. *Access to Aging Services*
   LGBT older people often do not access aging services out of fear of harassment or hostility. Few aging services providers plan for, or reach out to, the LGBT community—and few are prepared to address insensitivity or discrimination aimed at LGBT elders by staff or other older people.

Fortunately, such attitudes are changing. A recent survey of aging services providers shows that a growing number of respondents would welcome LGBT elders, but lack the proper training. Resources such as the federally funded National Resource Center on LGBT Aging have been created to provide training and tools to aging providers, LGBT organizations and LGBT older people themselves, ensuring that our community increasingly will be able to age with the dignity and respect we all deserve."

Discussion Questions:

1. What are the five unique challenges faced by LGBT community?
2. Do you agree that those five challenges are prevalent in our society? Give specific examples.
3. What challenge do you think most problematic as a barrier to optimal aging for LGBT elders?
4. Think about how LGBT elders and heterosexual elders differently experience and deal with aging.

Discussion Box 2.2: Age-related Physical Changes

Visit the link, Columbia University's ***Brave Old World*** Web site (http://news21.com/columbia/2011/2010/growing-old/index.html) and watch the four videos on age-related changes in vision, hearing, mobility, and thinking. After watching each video, answer the following questions.

1. Describe the changes you see taking place with aging.
2. When, approximately at what age, do you expect to undergo each of these changes? Why you chose that age?
3. What strategies and/ or information do you know to slow the rate of these changes? Give examples for each condition.

4. Think about how you manage your life once these age-related changes occur in your 60s or 70s?

Learning Exercises

Questions to Consider

1. What makes me a unique individual?
2. How will these qualities and interests be important to me as I age?
3. What scaffolding will I need to ensure for myself and my loved ones to support aging in a person-centered environment?

Experiential Learning

Visit www.gensilent.com and view the film trailer and review the following statistics in Fig. 2.4. What do you find most startling from this brief introduction to these cases? Why would any elder wait until near the end of life to reach out for assistance?

Resources

National Resource Center on LGBT Aging: See more at http://lgbtagingcenter.org/.

Services & Advocacy for Gay, Lesbian, Bisexual & Transgender Elders (SAGE): See more at http://www.sageusa.org/issues/general.cfm.

Caring and Aging with Pride: Learn more about aging and health needs of LGBT elders at www.caringandaging.org#sthash.qYHm9484.dpuf, http://www.centerforpositiveaging.org/lgbt.html#sthash.qYHm9484.dpuf.

LGBT Aging Resources Clearinghouse of the American Society on Aging (ASA): See more at http://www.centerforpositiveaging.org/lgbt.html#sthash.qYHm9484.dpuf.

Age-related physical changes at Meldline Plus' Web site http://www.nlm.nih.gov/medlineplus/seniorshealth.html.

Frequently asked questions answered by the American Psychological Association at http://www.apa.org/pubinfo/answers.html.

LGBT Aging Project at http://www.lgbtagingproject.org/.

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