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LGBT Aging: A Review of Research Findings, Needs, and Policy Implications

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Executive Summary

This report is a review of existing literature of lesbian, gay, bisexual, and transgender (LGBT) older adults and provides recommendations for future research and policy needs.

Although definitions vary, LGBT older adults include the population of sexual and gender minorities over the age of 50. With no census count available of LGBT older adults residing in the United States, investigators have used various methods to estimate the size of the population. One study estimates that there are over 2.4 million LGBT adults over age 50 in the United States, with the expectations that this number will double to over 5 million by 2030. Another study estimated that there are between 1.75 to 4 million LGBT adults above age 60. Without a national probability sample, accurate characterization of this population is difficult. However, numerous community-based, non-probability studies provide invaluable insight into the experiences of LGBT older adults and show that LGBT older adults face unique challenges to aging that their heterosexual, cisgender peers do not. Key findings from this review include the following:

Social Disparities

- LGBT older adults face barriers to receiving formal health care and social support that heterosexual, cisgender adults do not. Several studies report LGBT older adults avoid or delay health care, or conceal their sexual and gender identity from health providers and social service professionals for fear of discrimination due to their sexual orientation and gender identity.
- Compared to heterosexual cisgender adults, LGBT older adults have fewer options for informal care. LGBT older adults are more likely to be single or living alone and less likely to have children to care for them than non-LGBT elders. Studies find resilient LGBT older adults often rely on "families of choice" (families composed of close friends), LGBT community organizations, and affirmative religious groups for care and support.
- Financial instability and legal issues are major concerns among LGBT seniors. Lifetime disparities in earnings, employment, and opportunities to build savings as well as discriminatory access to legal and social programs that are traditionally established to support aging adults, put LGBT older adults at greater financial risk than their non-LGBT peers.
- LGBT older adults have experienced and continue to experience discrimination due to their sexual orientation and gender identity. Studies find LGBT older adults experienced high rates of lifetime discrimination and physical and verbal abuse in relation to their sexual and gender minority identity. One study found that LGB seniors searching for retirement homes experienced unfavorable differential treatment (less housing availability, higher pricing, etc.) compared to non-LGB seniors.

Health Disparities

- LGBT older adults have worse mental and physical health compared to heterosexual and cisgender older adults. LGB older adults have higher risks of mental health issues, disability, and higher rates of disease and physical limitation than their heterosexual counterparts. Compared to their cisgender peers, transgender older adults also face a higher risk for poor physical health, disability, and depressive symptoms, many of which are associated with experiences of victimization and stigma.
- Studies also find that LGBT older adults have a higher prevalence of engaging in risky health behavior, such as smoking, excessive alcohol consumption, and risky sexual behavior compared to non-LGBT older adults. However, LGBT older adults have higher rates of HIV testing than non-LGBT seniors.
- Among LGBT older adults, HIV-positive LGBT elders have worse overall mental and physical health, disability, and poorer health outcomes, and a higher likelihood of experiencing stressors as well as barriers to care, than HIV-negative LGBT elders.

Future Research and Policy Needs

- While community-based, non-probability studies provide important insight, they may not accurately represent the LGBT older adult population. Probability-based studies are needed to accurately characterize this population and generalize findings. Only two studies in this review used representative samples (both studies used state-level data) to characterize LGB older adults. To our knowledge, no probability sample of transgender older adults exists.
- Subgroups within the LGBT older adult population are understudied. In particular, we know little about bisexual, transgender, and intersectional subgroups (ie. older Black lesbians; Latina transwomen). Age-group specific analysis is also needed to provide better targeted interventions.
- From a policy perspective, LGBT older adults need to be recognized by the Older Americans Act (OAA) as a "greatest social need" group. This designation would open important funding avenues to prioritize services for and research of LGBT older adults. Other policy needs important to LGBT older adults are anti-discrimination legislation and expanding the definition of family to include families of choice.
- LGBT older adults are a growing population likely in need of more frequent health care and social support. From a service perspective, culturally sensitive training for health care and social service agencies and professionals that provide support to elders could be critical in alleviating expectations of and experiences of discrimination that many LGBT older adults fear when seeking healthcare and professional help.

Introduction

In this report, we provide a review of what is known about lesbian, gay, bisexual or transgender (LGBT) older adults. In doing so, we rely on previous reviews that have approached the study of LGBT older adults through various perspectives, such as through a life-course (Fredriksen-Goldsen & Muraco, 2010) or social historical perspective (Morrow, 2001). Some previous reports have focused on areas such as health and wellbeing or access and use of social services (Czaja, 2015; Addis et al., 2009; MAP & SAGE, 2010). We also rely on peer-reviewed articles, organizational reports, and books published regarding the experience of LGBT older adults in the U.S. and Canada (research focusing on populations outside of North American were not included in this report). We also draw upon expert and community members' perspectives as recorded in a special meeting convened by the Services and Advocacy for GLBT Elderly (SAGE) and the Administration of Community Living (ACL) in Denver, CO in November 2015. The meeting included 50 representatives from various organizations that study and serve LGBT older adults, including LGBT older adults themselves. Their perspectives are represented in text boxes throughout this report.

Although definitions vary, broadly LGBT older adults can be defined as the population of sexual and gender minority (SGM) individuals over the age of 50.[1] With no accurate census count of LGBT people, investigators used various methods to estimate the size of the population. Fredriksen-Goldsen, Kim, Shiu, Goldsen, and Emlet (2014) estimated that there are over 2.4 million LGBT older adults over age 50 in the U.S., with the expectation that this number will double to over 5 million LGBT adults over age 50 by year 2030. Other estimates suggest that 1.75 to 4 million American adults age 60 and over identify as LGBT (Administration on Aging, 2014).

The report suffers from lack of probability samples that can inform us about more accurate estimates of demographics, prevalence of diseases, conditions (e.g., disability), and health behavior and access to health care. Only two studies in this report used probability samples (both studies used state-level data) to characterize LGB older adults (Fredriksen-Goldsen et al 2013a; Wallace et al., 2011). To our knowledge, no representative data on transgender older adults exists. We rely on many studies that use various community-based sampling techniques (Meyer & Wilson, 2009). For that reason, we sometimes present findings that appear contradictory. As we do not have accurate national statistics, we are limited in our ability to judge which of the contradictory findings is correct and which is a function of the particular study's characteristics. Still, community-based studies provide invaluable data that enriches our knowledge about the variety of experiences that characterize LGBT aging.

[1] "Sexual and gender minority" is an all-inclusive term the U.S. federal government and National Institutes of Health has chosen to use that represents lesbian, gay, bisexual, and transgender populations as well as those whose sexual orientation, gender identity, gender expressions, or reproductive development fluctuates from societal, cultural, or physiological norms (NIH SGM Research Coordinating Committee, 2016).

To date, most studies on sexual and gender minority older adults focus on the extent to which sexual orientation, rather than gender identity, affects the aging experience of individuals. Even within sexual minority older adults, we find that we know most about gay men or lesbian women, with less research on bisexuals. Bisexuals are often included in an LGB category but rarely examined on their own so even less is known about the unique experiences of older bisexuals. Gender minority older adults, including transgender individuals, share many of the challenges and experiences of sexual minorities, and are often analyzed and reported under the LGBT umbrella. However, transgender older adults encounter specific challenges and often need different types of support and expertise, such as transition related medical care, of which LGB cisgender older adults do not. Despite these differences, research specific to transgender older adults is limited. Throughout the report, when available, we include research on transgender older adult specific issues, such as isolation and loneliness related to transitioning (Cook-Daniels, 2006; Cook-Daniels, 2015), discrimination and abuse by healthcare system and inability to conceal gender history to health professionals (Cook-Daniels, 2006), or challenges with finding adequate transition related healthcare (Cook-Daniels, 2006).

We note disparities in life experiences between transgender and non-transgender older adults. Transgender older adults experience high rates of discrimination in the work place and in healthcare settings, and experience high rates of lifetime verbal and physical abuse (Grant et al., 2011; Fredriksen-Goldsen et al., 2013b). In terms of health, transgender older adults have poor mental and physical health outcomes compared to non-transgender older adults (Fredriksen-Goldsen et al., 2011; Fredriksen-Goldsen et al., 2013b). When compared to their LGB cisgender counterparts, transgender older adults report higher rates of internalized stigma (Fredriksen-Goldsen et al., 2013b), which is associated with psychological distress, depression, and poorer health (Testa et al., 2015; Bockting et al., 2013; Fredriksen-Goldsen et al., 2013b). A higher proportion of transgender older adults also report suicide ideation compared to LGB cisgender older adults (Fredriksen-Goldsen et al., 2011) and are at higher risk for poor physical health and disability compared to non-transgender adults (Fredriksen-Goldsen et al., 2013b). Though we have some information, there remain many gaps in knowledge on transgender older adults and their aging experience. We recognize this, along with the gap in knowledge on bisexual older adults, as major areas of research need within the LGBT older adult population (See *Future Research and Policy Needs- Research Needs* section).

Like LGBT people in general, LGBT older adults are diverse with regard to many characteristics, such as gender, race/ethnicity, socioeconomic status, residential region, religiosity, and disability status. However, they share experiences of exposure to past and current stigma and prejudice and resiliency related to their sexual orientation or gender identity (Meyer, 2001). Studies of LGBT older individuals are typically not large enough to provide data into the influence of this great diversity on the lives of LGBT people at these different intersections.

Thus, many gaps to our understanding of LGBT older adults' characteristics exist. This makes it difficult to provide accurate information about demographic and other characteristics of the population.

In writing this report, we attempted to take an integrative approach to understanding LGBT older adults, the challenges they encounter, and their resiliency in addressing these challenges. Additionally, we provide recommendations on future areas of research. Finally, we suggest how to use this report in informing policy makers and stakeholders on issues pertinent to the LGBT older adult community.

Research Perspectives

The Institute of Medicine's report on LGBT health (2011) recommended that researchers consider four conceptual perspectives: The first perspective, *minority stress*, suggests that LGBT individuals experience stressors that stem from stigma and prejudice in social environments toward their sexual and gender minority identity (Meyer, 2003; Hendricks & Testa, 2012). Stressors include stressful major life events (e.g. assaulted because of being LGB), micro aggressions or everyday discrimination (e.g. receiving poor services in stores), expectations of rejections, concealment, and internalized stigma. The minority stress theory suggests that these stressors have adverse health effects on LGBT individuals. Against this stress, resilience from resources both at the individual and community level can ameliorate the impact of minority stress on health. The overall impact of minority stress is the balance of these negative and positive processes, which can lead to mental and physical disorders as well as growth and positive well-being (Meyer, 2015).

The second perspective, the *life-course* approach focuses on the principle stress and health needs and health outcomes that vary along ages and developmental periods. At the same time, the life-course perspective also takes a historical perspective, examining how events at each life stage can influence later stages, both from an individual (biological and social) and environmental (cultural and contextual) aspect (Cohler and Hammack, 2007; Elder, 1998). As a result of these different influences, the life course perspective teaches us to note important distinctions among different cohorts of LGBT older adults.

The third, *intersectionality* perspective alerts us to examine LGBT lives in the context of other important social identities and statuses, such as race/ethnicity, socioeconomic status, and areas of residence (e.g., urban vs. rural), and how these factors interact (McCall, 2009). For example, lesbian and bisexual Black women have unique experiences with stress, health, and identity associated with their sexual orientation, race/ethnicity, and gender that cannot be fully captured by considering race and gender separately (Bowleg, 2008; Brooks et al., 2009; Gamson & Moon, 2004; Moore et al., 2010).

The fourth perspective, *social ecology*, focuses our attention on understanding individual health and lives as influenced by factors outside of immediate environments such as families, relationships, community, and society (McLeroy et al., 1998). The social ecological perspective provides a framework to examine individual and population-level determinants of health (HHS, 2000, 2011). This framework can be used to think about the effect of environment on individual's health and different ways to approach health interventions.

Considering the life-course and social ecology perspectives, we note that the population of older LGBT people is distinct from the rest of the contemporary LGBT community in its social history. Today's older LGBT adults were born, and most came of age, before the 1969 Stonewall Inn Riots, considered the start of the modern Gay Liberation Movement (Morrow, 2001; Fredriksen-Goldsen & Muraco, 2010). The pre-Stonewall era was a time in which homosexuality was criminalized and considered a mental illness. Prejudice, stigma, violence, and discrimination prevailed throughout the social fabric and institutions of the U.S. Sexual minorities, especially gay men, were perceived as "interested in seducing innocent others" into their gay lifestyles (Morrow, 2001, p.155). This social environment led many LGBT individuals to conceal sexual and gender minority identities (Morrow, 2001; Fredriksen-Goldsen & Muraco, 2010; Kimmel et al., 2006).

Highlights from the 2015 Denver convening: Evaluating and Enhancing Aging Network Outreach to LGBT Older Adults

Social and physical isolation

Isolation has indirect effects on how LGBT older adults interact with others and seek health care. Reynaldo Mireles, Program Manager at SAGE of the Rockies, noted many LGBT older adults wait longer to ask for help and feel they cannot reveal their sexual orientation identity to providers. LGBT older adults also report feeling invisible at LGBT events such as pride festivals. Kathleen Sullivan, Director of Senior Services Department at L.A. LGBT Center and Chris Kerr, Clinical Director of Montrose Center in Houston Texas both shared that LGBT older adults who live outside cities or far from areas with LGBT populations are isolated from LGBT programs and services. Chris Kerr of Montrose Center in Houston, Texas also reported that many LGBT older adults travel long distances to find safe and friendly services and argued that peer outreach may be an effective approach to reaching aging LGBT populations.

As we study the population of older LGBT individuals in today's more accepting social environment, we ought to consider the influences of the social environment on their life experiences, exposure to stress and resilience, and health along their entire life-course.

Intersectionality gives this historical analysis greater definition. For example, one area that researchers explored is sexual identity development. Though lesbian and gay older adults share similar global historical experience, their identity development is influenced by subcultures, new outlooks, practical needs (such as help from church or neighbors in old age), individual life histories (such as a past heterosexual marriage), and point in life of coming out (Rosenfeld, 1999).

Social Issues affecting LGBT Aging People

As LGBT individuals age, they face unique challenges that their heterosexual peers do not. Aside from the challenges that all older adults face, such as physical limitations and changes in socioeconomic status or relationships, LGBT older adults confront discrimination from entities that are traditionally relied upon for support, and legal and financial barriers to preparing for older age (MAP & SAGE, 2010). A 2001 Administration on Aging study found that LGBT older adults are 20% less likely than their heterosexual peers to access government services such as housing assistance, meal programs, food stamps, and senior centers (MAP& SAGE, 2010; Czaja et al., 2015). LGBT older adults are also more likely to delay seeking health care and to avoid continuous care from the same health provider, partly due to fear of stigma and discrimination (Czaja et al., 2015). Below are areas LGBT older adults experience distinct challenges.

Isolation

LGBT individuals are less likely to be married than cisgender heterosexuals (Pew Research, 2013). Roughly 16% of LGBT adults reported being currently married compared to about 50% of adults in the general public (Pew Research, 2013). Specific to older LGB individuals, studies have found that a higher proportion of LGB older adults are single or tend to live alone compared to heterosexual elders (MAP & SAGE, 2010; Wallace et al., 2011). For transgender individuals, incidents of social isolation may be exacerbated by requirements set forth by medical professionals in the past to divorce one's spouse, move to a new area, and construct a new identity that fit with one's changed gender identity (Cook-Daniels, 2006). One activist stated "I have met people who were friends with transgender people prior to transition, who were told by their transgender friend that all contact had to cease as part of their treatment plan" (Cook-Daniels, 2015, p.195).

Isolation and fear of loneliness are major concerns of LGBT older individuals (Fredriksen-Goldsen et al., 2011). For example, nearly 60% of surveyed LGBT older adults in one study reported feeling a lack of companionship, and over 50% reported feeling isolated from others (Fredriksen-Goldsen et al., 2011). Among LGBT older adults, bisexual men and women were more likely to report loneliness than were gay or lesbian older adults (Fredriksen-Goldsen et al., 2011). Comparing transgender with cisgender older adults, transgender older adults reported higher levels of loneliness (Fredriksen-Goldsen et al., 2011). Looking only at sexual minorities, more often than heterosexual cisgender older adults, LGB older individuals live alone (Kim & Fredriksen-Goldsen, 2014; Wallace et al., 2011). Loneliness and isolation are associated with

poor health, while living with a spouse or partner and having a social support network mitigates the effects of loneliness among LGB older adults (Kim & Fredriksen-Goldsen, 2014; Grossman, D'Augelli, & Hershberger, 2000).

Access to Healthcare

For all aging adults, access and receipt of proper health care is critical. For LGBT older individuals, finding good healthcare can be especially challenging. Study results vary on whether LGBT older adults have less access to quality healthcare than heterosexual or cisgender older adults. Looking at LGB older adults compared with heterosexual older adults, some studies, based on probability samples, found no statistically significant difference in access to healthcare measured by whether respondent reported having delayed or not received medical care or prescription when felt needed, whether respondent visited the emergency room (ER), and number of doctor visits in the past year (Wallace et al., 2001), and no difference in prevalence of having a health care provider (Wallace et al., 2011; Fredriksen-Goldsen et al., 2013a). However, LGB older adults are less likely to have health insurance and more likely to face financial barriers to healthcare than do their heterosexual counterparts (Fredriksen-Goldsen et al. 2013a).

But other studies that use non-probability community samples, show that LGBT older adults may feel distrust toward health and social service agencies, and avoid or delay health care for fear of discrimination due to their sexual orientation or gender identity (Beeler, Rawls, Herdt & Cohler, 1999; Cahill, South & Spade, 2000; Brotman et al., 2003; Croghan, Moone, & Olson, 2012; Wallace et al., 2011, Cook-Daniels, 2006). Incidents of overt homophobia or transphobia from healthcare providers toward older sexual and gender minority adults are common (Brotman et al., 2003; Cook-Daniels, 2015; Czaja et al., 2015). One respondent recalled how "when he got into the nursing home and they found out he was gay, they refunded him his money and threw him out" (Czaja et al., 2015, p.6). Another respondent shared his experience of witnessing nurse aids provide sub-quality care to an older gay patient because of their homophobia (Czaja et al., 2015). In a different study, a transgender older adult reported "One Navy doctor refused me care when a suture site related to my sex reassignment surgery became infected" (Cook-Daniels & munson, 2010, p. 156).

Respondents in a study conducted in the Mid-West reported that even before experiencing any discrimination from senior services, they believed they would not receive friendly services if providers became aware of their minority sexual orientation or gender identity (Croghan, Moone, & Olson, 2014). As a result of fear of discrimination, LGB elders may conceal their sexual orientation from their health care provider (Harrison & Silenzio, 1996). In turn, concealment of one's sexual minority identity can be damaging to LGB older adults seeking health care, for both medical and psychological reasons. Gay and bisexual older adults who reported their providers are aware of their sexual minority identity reported better perceived health and lower depression compared to those who reported their providers are unaware of their sexual orientation (Ramirez-Valles, Dirkes, & Barret, 2014).

Different from LGB older adults, many transgender older adults do not have the option to conceal their gender history to health professionals as their body may reveal scars and other evidence that contradict their gender appearance when dressed (Cook-Daniels, 2006). Because of this, transgender individuals may be more susceptible to discrimination and abuse by health professionals, and this is particularly the case for transgender older adults who may seek more frequent and intimate health care due to age related physical conditions and disabilities (Cook-Daniels, 2006).

Caregiving

LGBT older adults have fewer options for receiving informal caregiving than their heterosexual peers. Heterosexual older adults typically turn first to their spouse or children, second to their parents or siblings, third to in-laws or spouse's family, and fourth to friends and other informal caregivers before finally seeking professional or institutional care for care and social support (MAP & SAGE, 2010; Barker et al., 2006). LGBT older adults are less likely than heterosexual adults to have children to help them (de Vries, 2009; SAGE & Hunter College Brookdale Center, 1999) and may also be estranged or continue to conceal their sexual orientation from their biological families for fear of lack of acceptance (MAP & SAGE, 2010). As a result, LGBT older adults tend to rely more heavily than cisgender heterosexual older adults on friends or "families of choice"—families composed of close friends—and do not have many intergenerational levels of support that heterosexual aging adults typically have (Grossman et al, 2000). One study of gay men in New York City found that gay men were not more isolated than heterosexual men, but were more likely than heterosexual men to call on friends and partners than family (Shippy et al., 2004). Though caregiving received through friends and partners is critical, Barker and colleagues (2006) argue that the same social expectations for long-term care and support that exists for biological kin do not exist within friends, possibly lending to less reliable care among sexual minority older adults.

Financial Instability and Legal Issues

Many LGBT older adults indicate they worry about financial stability as they age (Alliance Healthcare Foundation, 2003; de Vries et al., 2009). Though financial instability is a concern for all aging adults, LGBT older adults face additional challenges because of disparities in access to legal and social programs, particularly related to recognition of legal partnership, lifetime earnings, and opportunities to build savings.

Until recently, same-sex couples faced discrimination in accessing federal government benefits. In *U.S. v. Windsor* (2013), the U.S. Supreme Court held that the federal government must treat married same-sex couples the same as married different-sex couples for purposes of federal benefits. Prior to *Windsor,* members of same-sex couples were unable to access federal benefits programs built to provide financial assistance to older adults. For example, LGBT older adults in same-sex couples were unable to access benefits from federal programs such as social security,

Medicaid and long-term care, retirement plans, or retiree health insurance plans the same way adults in different-sex marriages could, even if their marriage was recognized at the state-level (MAP & SAGE, 2010; Funders for Lesbian and Gay Issues, 2004; Goldberg, 2009). After *Windsor*, married same-sex couples who lived in states that recognized their unions had access to all federal benefits that flow from marriage. However, couples who lived in states that did not recognize their marriages continued to have limited access to benefits. Couples who could not or chose not to travel out of state to marry did not have access to any federal benefits. The U.S. Supreme Court's decision in *Obergefell v. Hodges* (2015) extended marriage equality nationwide, ensuring that same-sex couples can access federal benefits related to marriage no matter where they live. LGBT older adults who are married are now included in the programs that they were denied previously, but some challenges may continue that affect recently married or currently unmarried LGBT older adults. For example, the 9-month duration of marriage to qualify for social security survivor benefits could be restrictive to an LGBT older adult who recently married but their spouse passed away in the interim (Marriage Equality FAQ).

Furthermore, many older same-sex couples may not choose to marry as they already made legal, financial, and other arrangements to formalize their relationships. Older same-sex couples also may have never developed an expectation or desire for marriage, as it was not an option for most of their lives. Additionally, many LGBT older adults rely on "families of choice" or alternative family structures, which could not be included under the definition of formal marriage because they comprise networks of friends of various sizes but not intimate couples. For unmarried same-sex couples or individuals in alternative family structures, some challenges that existed prior to marriage equality remain. For example, benefits that are automatically granted to the surviving partner of marriage are not granted to surviving unmarried same-sex partner (without extensive estate planning and legal processes), and can be financially devastating for the surviving partner, especially if a high-earning partner passes away. Similar issues can arise if a partner needs to enter long-term care. In terms of estate or tax laws, a surviving unmarried partner may be subject to various estate tax requirements to inherit shared property, and without a set of specific legal arrangements that are often very costly, LGBT older adults in same-sex relationships do not have the confidence that they will inherit the property and assets they shared with their partner (MAP & SAGE, 2010).

Aside from discriminatory social and legal programs, many LGBT individuals worked or currently work in an environment where discrimination based on sexual orientation and gender is legal. Though changes are happening on this front, such as the U.S. Equal Employment Opportunity Commission (EEOC) interpreting Title VII's prohibition of sex discrimination to include discrimination based on gender identity and sexual orientation (U.S. EEOC, 2016), legal discrimination based on LGBT status or perceived status persists. This can translate to limited job opportunities, lower income, fewer opportunities to build savings and accumulate wealth for older LGBT adults—all with serious ramifications in older age (MAP & SAGE, 2010).

Gender, gender identity, and sexual orientation affect earnings in different ways. Gay and bisexual men, on average, earned 10-32% less than heterosexual men (Badgett, Lau, Sears, & Ho, 2007). Lesbian and bisexual women, on the other hand, earned the same or more than heterosexual women, but less than men in general (Badgett et al., 2007). Badgett and colleagues (2007) also reported that transgender individuals had high rates of unemployment and low wages, but they did not have a cisgender comparison group. To our knowledge, there is no study on earnings and savings of transgender older adults, though we do have some insight into how same-sex couples fair compared to different-sex couples in older age. "Same-sex couples are disadvantaged in retirement assets, retirement savings, and the ability to pass on wealth" (Goldberg, 2009, p. 2). Same-sex couples also have a higher rate of poverty compared to heterosexual married couples (Goldberg, 2009 in MAP & SAGE, 2010). Lesbian older couples, in particular, are 10-20% less likely than different-sex couples to have retirement income or interest and dividend income, and are much more likely to receive public assistance (Goldberg, 2009).

The accumulated effect of disparities in access to government programs, earnings, and saving as well as the inability to seek legal protection from discriminatory practices can lead to financial instability among LGBT older adults. At the same time, awareness of these legal and financial challenges seems to have manifested in better preparation for later life for some. Sexual minority older adults, particularly those who are coupled, are more likely to be prepared for later life (i.e., setting up a will or a durable power of attorney) than their heterosexual counterparts (de Vries et al., 2009).

Housing

Housing discrimination is a primary concern among LGBT older adults (Equal Rights Center, 2014). Housing decisions can be even more critical for older adults as issues of mobility, limited income earning opportunities, and proximity to social support need to be considered (Equal Rights Center, 2014). Though not specific to LGBT older adults, one experiment conducted by the Michigan Fair Housing Center, found that 26% of houses tested treated same-sex couples differently by either quoting higher monthly rent or denying housing applications (Michigan Fair Housing Center, 2007). Another study that surveyed transgender adults found that 19% were refused a home or apartment and 11% were evicted because of their gender identity or expression (Grant et al., 2011).

Sexual minority older adults may also face discrimination when searching for retirement homes and senior housing (Cahill & South, 2002). In a nationwide matched-pair study, in which an LGB identified senior and heterosexual identified senior contacted the same senior housing community to determine availability, nearly half of the tests (48%) showed that the LGB identified senior experienced unfavorable differential treatment in terms of availability of

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In Search of Safe Spaces

On a panel of program managers and directors serving LGBT older adults through LGBT centers or aging service networks, creating safe spaces was indicated the most pressing need within the LGBT older adult community. LGBT older adults lack safe and affordable housing and a communal and safe space to share information or talk openly about their concerns. Without a shared safe space, LGBT older adults remain invisible, isolated, and ignored. Safe spaces are particularly a concern for transgender older adults. Gloria Allan, founder of a charm school program for transwomen at the Center on Halsted in Chicago, voiced a lack of safe environments for transwomen of color in medical offices, senior housing centers, and social services. Furthermore, she expressed that "security and safety responses from policy and other agencies often is insufficient" in providing a safe environment. With nowhere to go, transwomen of color can suffer from mental health, substance abuse and other social challenges.

housing, pricing, financial incentives, amenities, or application requirements (Equal Rights Center, 2014). In 2012, the U.S. Department of Housing and Urban Development (HUD) issued the "Equal Access Rule" which ensures that any HUD-assisted or insured housing is made available to individuals regardless of actual or perceived sexual orientation, gender identity or marital status (U.S. HUD, 2015). This is an important step toward recognizing discrimination exists and protecting LGBT older adults and individuals looking for government-subsidized housing. Additionally, LGB-friendly housing is available in some parts of the U.S., but such housing is mostly available to upper-income LGB older adults (Cahill & South, 2002).

Stressors

Minority stress theory suggests that sexual and gender minorities are exposed to unique stress related to stigma and prejudice and that this stress leads to adverse health outcomes (Meyer, 2003; Hendricks & Testa, 2012). Minority stressors include external events and conditions, such as major life events, everyday discrimination (smaller magnitude events, such as daily hassles, or micro-aggressions), as well as more proximal (internalized) stressors such as internalized stigma, expectations of rejection and discrimination, and concealment of one's sexual or gender identity. Research has shown that LGBT individuals experience more stress than cisgender heterosexual people and, in turn, this leads to health disparities based on sexual orientation and gender identity (IOM report, 2013). Research has shown that stressful experiences for LGBT individuals begin when they are children and impacts the school experience and health of LGB youth (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Ryan, Huebner, Diaz, & Sanchez, 2009; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011; Toomey, Ryan, Diaz, Card, & Russell, 2010). For

example, compared with heterosexual, cisgender, youth, LGBT youth experience higher levels of assault, violence, and harassment and feel unsafe at school (Safe Schools Coalition of Washington, 1999; GLSEN, 1999). Fewer studies have analyzed how LGBT older adults experience stressors generated by stigma and discrimination due to their sexual and gender minority status, particularly if stressors are experienced during older age.

Prejudice Events

Prejudice events refer to events stemming from antigay prejudice, discrimination, and violence. Prejudice events include the *structural* exclusion of LGB individuals from resources and advantages available to heterosexuals, including their exclusion from the institution of marriage discussed herein. Prejudice events also include *interpersonal* events, perpetrated by individuals either in violation of the law (e.g., perpetration of hate crimes) or within the law (e.g., lawful but discriminatory employment practices). There are numerous accounts of the excess exposure of LGB people to such prejudice events (Herek, 2009; Herek et al., 2009; Meyer 2003; Meyer, Schwartz, & Frost, 2008).

Hate crimes are a particularly painful type of event because they inflict not only the pain of the assault itself, but also the pain associated with the social disapproval of the victim's stigmatized social group. The added pain is associated with a symbolic message to the victim that he or she and his or her kind are devalued, debased, and dehumanized in society. Such types of experiences affect the victim's mental health because it damages his or her sense of justice and order (Garnets, Herek, & Levy, 1990 in Meyer, 2003; Herek, Gillis, & Cogan, 1999).

One example of a hate crime that reverberates well beyond the victims of the event is the June 12, 2016 mass shooting in an LGBT nightclub. It is the deadliest mass shooting in U.S. modern history, which took the lives of 49 people and injured 53 at the nightclub Pulse in Orlando, Florida (Zambelich & Hurt, 2016). The complex motives behind the attack remains unknown but it appears that the shooter knowingly targeted a gay club, a historically "safe" space within the LGBT community, and thereby attacked people based on their sexual orientation and gender identity (D'Addario, 2016). This hate crime directly targeted the LGBT community and was a reminder that despite the social and legal advancements in gaining rights for LGBT individuals, the community is still a targeted minority group (Lawrence, 2016).

It is not only the pain of the assault but the pain reverberated through the act of the entire community's disapproval, derision, and disdain. The added symbolic value that makes a prejudice event more damaging than a similar event not motivated by prejudice exemplifies an important quality of minority stress: Prejudice events or even everyday instances of prejudice (*everyday discrimination)* and non-events can have a powerful impact "more because of the deep cultural meaning they activate than because of the ramifications of the events themselves . . . a seemingly minor event, such as a slur directed at a gay man, may evoke deep feelings of rejection and fears of violence [seemingly] disproportionate to the event that precipitated them"

(Meyer, 1995, p. 41-42). Therefore, stress related to stigma is not assessed solely by its intrinsic characteristics but also by its symbolic meaning within the social context: even a minor event or instance can have symbolic meaning and thus create pain and indignity beyond its seemingly low magnitude.

In a national community-based sample study of LGB older adults across the U.S., Fredriksen-Goldsen and colleagues (2013c) reported that LGB older adults on average experience victimization and discriminatory events six times in their lifetime. Additionally, the researchers found that those who reported experience of victimization in their lifetime had poorer general health, a higher likelihood of disability, and a higher likelihood of depression (Fredriksen-Goldsen, 2013c). In another study analyzing 416 LGB older adults aged 60-91, Grossman and colleagues (2002) found that victimization due to minority sexual orientation status was an important risk factor for poor mental health.

Using the same sample of LGB older adults, D'Augelli and Grossman (2001) examined lifetime victimization experiences due to sexual minority status. LGB older adults who disclosed their sexual orientation at an earlier age and were open about their sexual orientation experienced more victimization (D'Augelli & Grossman, 2001). Physical victimization in particular was associated with longer time being open about one's sexual orientation and was tied to lower self-esteem (D'Augelli & Grossman, 2001). Regardless of time being out, however, 63% of respondents reported to have experienced verbal abuse and 30% reported being threatened with violence at some point in their life due to their sexual orientation (D'Augelli & Grossman, 2001). Some respondents also reported having been threatened with disclosure of their sexual orientation. Experiences with victimization and discrimination also differed by gender, as sexual minority older men reported higher incidences of being physically attacked in their lifetime than did sexual minority older women (D'Augelli & Grossman, 2001). Victimization and discrimination experiences between older and younger LGB adults have also been compared. Older adults, particularly older gay men compared to younger gay men, reported fewer incidents of victimization and discrimination than younger LGB adults and youth (Dean et al, 1992; Herek et al.,1997).

Highlights from the 2015 Denver convening: Evaluating and Enhancing Aging Network Outreach to LGBT Older Adults

Lived Experiences of LGBT Elders: Discrimination

As a transgender woman, Dana Wallingford, has experienced isolation, marginalization, and a lack of culturally competent health services. Dana shared her experience of being kicked out of a local recreation center restroom being told "you haven't had the surgery yet". She has not felt comfortable at that recreation center since, and feels self-conscious at the new recreation center she frequents. Dana reports suffering from depression and anxiety.

To our knowledge, however, no study provides data on current or recent victimization and discrimination experiences due to sexual orientation among older LGB adults. This knowledge gap demonstrates a research need to focus on the current or recent lived experiences of LGB older adults.

Studies on victimization based on gender identity are more limited. Fredriksen-Goldsen and colleagues (2013b) found that compared to an average of 6 lifetime incidents among cisgender older adults, transgender older adults experienced an average 11 incidents of victimization and discrimination including verbal insults, being threatened with physical violence, not being hired for a job, being denied or provided inferior health care, being denied a promotion, or being hassled by the police. Seventy-six percent of the 174 self-identified U.S. transgender older adults in the survey reported experiencing verbal abuse and more than 54% reported being threatened with physical violence. Over one-third of the transgender older adults reported experiencing discriminatory events such as denial of healthcare, denial of promotion, and unfair treatment from police. Professional or government officials are sometimes the source of abuse and mistreatment that transgender individuals experience (Grant et al., 2011), making it difficult for individuals to report to authorities in fear that authorities may respond with hostility or apathy (Cook-Daniels, 2006). One transgender older adult who was residing in a long-term care facility shared his experiences of sexual abuse and verbal harassment from nurse aids with his social worker. Though the social worker discussed options to report the harassment and abuse, the transgender older adult refused to report the incidents out of fear of retaliation from the nurse aids and disclosure of his transgender status to his family (Cook-Daniels, 2006).

Internalized Stigma (Internalized Homophobia and Internalized Transphobia)

Internalized stigma (also described as *internalized homophobia and internalized transphobia*) refers to the internalization of negative societal attitudes about LGBT people toward oneself. For example, internalized transphobia refers to the internalization of anti-trans attitudes and beliefs, such as the belief that people's gender is consistent with their biological sex assigned at birth and therefore trans individuals are imposters who are not truly who they say they are. Internalized transphobia manifests when transgender individuals feel negatively about their own gender identity and about the transgender community (Testa et al., 2015). Internalized stigma is an insidious stressor because it is unleashed by the person toward the self through years of socialization in a stigmatizing society (Meyer, 2003, Herek et al., 2009). Heterosexual cisgender people, just like LGBT individuals, internalize homophobia and transphobia, but the effects of this internalization is quite severe for LGBT persons who must learn to dissociate their sense of self from what they have learned as members of society about being LGBT.

Internalizing stigma has negative consequences for the health and well-being of LGBT people. Because internalized homophobia disturbs the gay person's ability to overcome stigmatized notions of the self and envision a future life course, it is associated with mental health problems and impedes success in achieving intimate relationships (Meyer, 1995; Meyer & Dean, 1998;

Frost & Meyer, 2009). Similarly, internalized transphobia is associated with overall psychological distress and other mental health problems (Testa et al., 2015; Bockting et al., 2013).

LGBT older adults spent their formative and much of their early adult years in a social, political, and medical environment in which homosexuality was considered a mental illness and same-sex sexuality (sodomy) was illegal (D'Augelli et al., 2001). Given this historical background, internalized stigma is an important concept to explore among LGBT older adults. However, the effect of internalized homophobia and transphobia on LGBT older adults is less clear because few studies have examined this question within this population. One study found that LGB older adults had high self-esteem levels and low levels of internalized homophobia, with 80% reporting they were "glad to be LGB" and 8% reporting feeling depressed with regard to their sexual orientation (Grossman, D'Augelli & O'Connell, 2002). The authors also found that men tended to report higher levels of internalized homophobia than women did. For gay men, in addition to internalized homophobia, internalized ageism leads to aging related-stress, which, coupled with internalized stigma, is associated with depressive symptoms (Wight et al., 2015) and mental health issues (Wight et al., 2012). Among older LGB adults, internalized homophobia was a predictor of increased disability and depression, but was not associated with poor general health (Fredriksen-Goldsen, et al., 2013c). In a more recent study, however, researchers found that internalized homophobia was associated with chronic physical health conditions (Hoy-Ellis & Fredriksen-Goldsen, 2016).

In the study mentioned above on transgender older adults, transgender older adults reported higher rates of internalized stigma than cisgender LGB older adults (Fredriksen-Goldsen et al., 2013b). Internalized stigma, along with other stressors, was associated with poorer health, higher degrees of depression, and perceived stress.

Concealment of Sexual and Gender Identity

Concealment refers to an LGB or transgender person hiding their sexual or gender identity from others. It is typically used as a coping mechanism, to prevent being subject to prejudice, discrimination, or violence. But concealment is also a stressor and can have negative health consequences (Meyer, 2003). First, people must devote significant psychological resources to successfully concealing their LGB identity. Concealing requires constant monitoring of one's interactions and of what one reveals about his or her life to others. Keeping track of what one has said and to whom is very demanding and stressful, and leads to psychological distress. Among the effects of concealing are preoccupation, increased vigilance of stigma discovery, and suspiciousness (Pachankis, 2007). The concealing effort, and the required cognitive efforts can lead to significant distress, shame, anxiety, depression and low self-esteem (Frable, Platt, & Hoey, 1998). Second, concealing has harmful health effects by denying the person who conceals his or her LGB identity the psychological and health benefits that come from free and honest expression of emotions and sharing important aspects of one's life with others (Pachankis, 2007).

Third, concealment prevents LGB individuals from connecting with and benefiting from social support networks and specialized services for LGB individuals. Protective coping processes can counter the stressful experience of stigma (Meyer, 2015). Coping processes include the group's effort to counter negative societal structures by creating alternative norms and values and providing role models and social support. Access to and use of such community resources is beneficial to stigmatized minority group members whose experiences and concerns are not typically affirmed in the larger community. For example, LGB communities have provided role models of successful same-sex intimate couples, have provided alternative values that support LGB families, and, in general, have countered homophobic messages and values (Weston, 1991). LGB people who conceal their sexual identity would avoid, in an effort to maintain secrecy, such organizations or venues (e.g., gay or lesbian media, a gay community center, and other gay or lesbian community venues such as a gay pride day celebration). In addition, LGB people who need supportive services, such as competent mental health services, may receive better care from sources in the LGB community (e.g., a specialized gay clinic; Potter, Goldhammer, & Makadon, 2008). But individuals who conceal their LGB identity are likely to fear that their sexual identity would be exposed if they approached such sources. More generally, concealing can lead to social isolation as the person who conceals his or her sexual identity may avoid contact with other LGB persons but also feel blocked from having meaningful honest social relations with non-LGB individuals. As mentioned above, while many LGB individuals have the option of "passing" or concealment, transgender people do not always have this option, particularly with health providers who have access to past medical records or can see transition related body scars (Cook-Daniels, 2006).

Concealment is intertwined in the stories of many LGBT older adults, and can become a central issue as long-term or advanced health care and end-of-life planning become imminent. In a study of LGB older adults, the median age of first awareness of sexual orientation was 12 and the median age of first disclosure of sexual orientation was 23, while some respondents spent little time in the closet, others spent almost their entire lives concealing their sexual orientation (D'Augelli & Grossman, 2001). More than half of the respondents reported that either one or both parents or siblings did not know their LGB status (D'Augelli & Grossman, 2001). Among LGBT older adults with children, a higher proportion of fathers than mothers reported concealing their sexual orientation from their children (D'Augelli & Grossman, 2001). Differences in concealment also exist by gender, as women reported more openness about their sexual orientation than men (Jacobs, Rasmussen, & Hohman, 1998) and women reported that more people knew of their sexual orientation than men did (D'Augelli & Grossman, 2001). The stress of concealment and disclosure for LGBT older adults is most prominent in the context of health services, particularly long-term care services (See *Health Services-Advanced care/End-of-life care* section).

Expectations of rejection

Expectation of rejection and discrimination is a stressor because of the almost constant vigilance required by members of minority groups to defend and protect themselves against potential rejection, discrimination, and violence (Meyer, 2003). Unlike the concept of prejudice events, where a concrete event or situation—a major or minor life event or a chronic stressor—was present, expectations of rejection and discrimination are stressful even in the absence of a prejudice event. "Because of the chronic exposure to a stigmatizing social environment, 'the consequences of stigma do not require that a stigmatizer in the situation holds negative stereotypes or discriminates'" (Crocker, 1999, in Meyer, 2003, p. 681).

Although research has not studied this extensively, it is likely that expectations of rejection will be a factor in concealing sexual or gender identity and may play out most prominently in employment, health care settings, residential care, and in seeking support from non-LGBT persons. Thus, about one-third of lesbian and gay older adults identified discrimination due to sexual orientation as their greatest concern about aging (MetLife, 2006). Older lesbians feel their job would be in jeopardy if their sexual orientation were known (Jacobs, Rasmussen, Hohman, 1998). Older LGBT people may also expect dealing with insensitive professionals and policies in hospitals and other organizations. Respondents in one study were especially apprehensive about in-home services and attending straight support groups. One respondent shared this anticipation and fear of discrimination by professionals, saying: "Even though I was not treated badly, I always had that fear that I could be treated badly . . . there is always a threat that you carry around in your heart that they can be bad to you" (Hash, 2008, p. 133).

Resilience Factors for Successful Aging

In the face of stressors such as those described above, LGBT people display resilience through coping and social support. The minority stress model predicts that the impact of stress on LGBT populations is ameliorated by resiliency so that the outcome of stress is determined by the efficiency of salutogenic coping and social support to counter the adverse impact of stress (Meyer, 2003). Thus, studies show that many LGBT older adults are well-adjusted, happy, and thriving (Fredriksen-Goldsen et al., 2014; Van Wagenen et al., 2013; Kimmel, Rose, & David, 2006). These results conflict with above study results that focus on the negative experiences and stressors of LGBT older adults. However, these conflicting results may be because the focus and approach of the studies is different, studies that examine resilience will have different approaches and constructs to measure than studies that look at victimization and discrimination experiences. To further explore how LGBT older adults are aging in terms of resiliency, a few studies have looked at *successful aging* in LGBT populations. Though the concept of successful aging and its many dimensions have been thoroughly examined in gerontology (Van Wagen, Driskell, & Bradford, 2013) and applied to studies on the general aging population, little research exists around subpopulations and minority groups (Phelan et al, 2004; Laditka et al, 2009; Van Wagen et al, 2013), particularly sexual and gender minority groups.

Of the few studies that have theorized or examined what "successful" aging looked like among LGBT older adults, ability to be resilient in the face of difficulties or "crisis competency" was an important theme (Friend, 1991; Van Wagen et al, 2013; Fredriksen-Goldsen, Kim, Chiu, Goldsen & Emlet, 2014). Resilience, the "behavioral, functional, social, and cultural resources and capacities utilized under adverse circumstances" (Fredriksen-Goldsen, et al. 2013c p.3), aside from the other traditional metrics of successful aging such as physical, mental, and emotional health, is a critical dimension to understanding how well LGBT older adults age.

The ability to cope with adversity is an indication of resilience. Coping mechanisms can be understood at the individual level and at the group level (Meyer, 2003). Individual coping is personal strengths or characteristics, such as having a positive outlook or determination when dealing with stressful situations (Branscombe & Ellemers, 1998 in Meyer, 2003). Group coping, common among minority groups, provides individuals with a sense of unity by creating a positive environment of support and protection (Branscombe & Ellemers, 1998 in Meyer, 2003). For LGBT older adults, much of the literature on coping focuses on group coping mechanisms or social support networks.

Social Support

Studies have found positive effects of social support among LGBT older adults (Ramirez-Valles, Dirkes, & Barret, 2014; Fredriksen-Goldsen et al, 2001; MAP & SAGE, 2010). A larger number of people in one's social network is associated with better health (Ramirez-Valles et al 2014). Social support not only serves as a function of support toward aging but also in dealing with lifelong stigma and discrimination of being LGB (D'Augelli & Grossman, 2001). Social support has been associated with better health outcomes (White et al., 2009), as a safeguard to stigma and effects of discrimination (D'Augelli, Grossman, Hershberger, & O'Connell, 2001; Silliman, 1986), better general health and higher quality of life (Fredriksen-Goldsen et al., 2015), and decreased depression and internalized stigma (Masini & Barrett, 2008). In a study using a national community-based sample of LGBT older adults, 67% of respondents reported they had someone to help with daily chores if sick, 82% reported they had someone to turn to for help with personal problems, and 71% said they had someone to love or who made them feel loved (Fredriksen-Goldsen et al., 2011). Older individuals who were supported by people who knew of their sexual orientation had higher levels of satisfaction with their support and felt in control of their loneliness compared to those who were supported by people who were unaware (Grossman et al., 2000).

The most common and most studied form of social support network among LGBT adults and LGBT older adults is "families of choice" (Barker, Herdt & de Vries, 2006; Croghan et al., 2014; Brennan-Ing et al., 2014; MAP & SAGE, 2010). Families of choice refer to partners, friends, and other individuals such as neighbors, who are considered and act in place of one's biological family. Many LGB older adults in particular who left or were kicked out of home as youth often

found support in large urban areas, among people like themselves (Barker, Herdt, & de Vries, 2006). LGB older adults turned to each other for the support that families were unable or unwilling to provide (Barker, Herdt, & de Vries, 2006). A survey of 495 older adults in the Twin Cities Metropolitan area found that 75% of older LGBT people reported having a chosen family (Croghan et al., 2012). Another survey based in the Midwest found that LGBT older adults on average received more types of care from families of choice than from their biological families (Brennan-Ing et al., 2014). In a study of older gay and bisexual men in New York City, among the 36% who were partnered, the majority (70%) reported relying on their partners for primary support (Shippy, Cantor, & Brennan, 2004). In the absence of a partner, about 40% reported counting on friends for support rather than any existing family, though not all friendships were functional in terms of providing instrumental and emotional support (Shippy, Cantor, & Brennan, 2004). Masini & Barrett (2008) also found LGB adults who got support from friends rather than family reported better mental health and lower levels of depression.

Few studies have also analyzed what individual characteristics are associated with social network size and the characteristics of one's social support network. In a New York City study, Frost, Meyer, and Schwartz (2015) found significant gender differences related to major support (e.g., help with money), with GB men relying mostly on other LGBT friends, and LB women relying mostly on family of origin. Using data from a large community-based sample across the U.S., Erosheva and colleagues (2015) found that certain demographic characteristics, such as being female, transgender, employed, with higher income, and having a partner/child were associated with having a larger social network. Many of the same factors were also associated with having a network that was diverse in terms of sexual orientation and gender identity. Consistent with minority stress theory, Meyer, Schwartz, and Frost (2008) found that race/ethnic minorities (Blacks and Latinos) had fewer resources than White LGB and heterosexual respondents.

For many LGBT older adults, families of choice seem to be a major source of social support. However, relying primarily on families of choice can be challenging as older adults may feel they have fewer opportunities to make new connections (Zians, 2011) as friends fall away or face their own physical challenges with aging or disease. Shippy and Karpiak (2005) found that while most sexual minority men with HIV relied on friends who were also HIV positive, nearly 30% reported that they have only themselves to rely upon or that wouldn't know where to turn for help. Another challenge for LGBT older adults and social support is that many of their families of choice belong to the same generation and cannot provide support (MAP & SAGE, 2010) such that younger friends could provide. Although 73% of respondents in a San Diego based survey on older LGBT people reported having younger friends, only 30% believed they could count on these friends for support (Zians, 2011).

Support from LGBT Community Organizations

Another source of support is through LGBT community organizations. Though disclosure of sexual orientation and gender identity can lead to experiences of victimization and

discrimination, one major benefit of disclosure is the opportunity to connect and become involved with the broader LGBT community and LGBT-specific organizations. Being part of a larger unifying community can serve as an important social network and 89% of LGBT older adults reported they were proud to be part of the LGBT community (Fredriksen-Goldsen et al., 2011). Additionally, in a recent report surveying LGBT community centers, 61% of the 105 community centers noted that they provided services tailored to older adults and many had programs focused on LGBT older adult outreach or physical and mental health programs (CenterLink & MAP, 2016).

Two empirical studies have analyzed LGB older adults' engagement and attitude toward LGB service organizations. Quam and Whitford (1992) found that gay and lesbian adults over the age of 50 living in the Midwest were more likely to engage in gay and lesbian social groups than in senior recreation center activities for the general population. Similarly, in a more recent study in San Diego County, Jacobs and colleagues (1999) found that LGB older adults believed LGB specific social and support groups better met their needs in times of crisis than non-LGB specific support systems. Furthermore, about 80% reported that LGB-specific social services provided adequate support, though 30% reported they could not locate a LGB support center when in need.

The two studies indicate that LGB older adults can benefit from and enjoy participating in the LGBT community and organizations. In fact, almost 50% of respondents from the San Diego County study reported they would not participate in LGB support services if they were provided by a non-LGB service organization (Jacobs et al., 1999). Despite this show of support, a common challenge LGBT older adults face is feeling unwelcomed by the larger LGBT community and organizations (MAP & SAGE, 2010).

Highlights from the 2015 Denver convening: Evaluating and Enhancing Aging Network Outreach to LGBT Older Adults

Current State of Services Provided to LGBT Older Adults by Aging Networks
Aging network representatives from Florida, Georgia, Hawaii, and New York discussed how their networks served LGBT older adults.

Jacksonville, Florida: LGBT older adult representation at aging networks is low but improving. While the aging community is aware of the LGBT community, they do not believe LGBT older adults have different issues often saying "we don't have a problem here." Many elder service providers also believe everyone should be treated equally, which can lead to isolation of LGBT older adults. Raising community awareness of LGBT older adult issues is necessary and Eldersource now requires culturally competent service training to all staff and contractors. Another issue is the lack of information on the extent to which LGBT older adults access aging

services. State data collection systems do not collect or track LGBT data and resources. Aside from anecdotal information, we do not have a good sense of what kind of services LGBT older adults need. Some things that would help support a better LGBT older adult experience in Florida is to mandate state agencies to collect LGBT data, train providers in LGBT issues, and encourage state-to-state sharing of best practices.

- Linda Levin, Executive Director, ElderSource

Atlanta, Georgia: Georgia has the 8th largest LGBT population in the country and while many statewide systems have been implemented, things move slowly and there is still much to do. The state has provided culturally competency trainings, worked with service providers to establish a database of LGBT friendly providers, and updated intake and other materials to include LGBT elements. However, there is some pushback internally on making LGBT elder services a priority, such as employees resisting including LGBT questions in client interactions. Additional funding to implement systematic improvements in training availability would help improve the experience of LGBT older adults in Georgia as there are many disparities for both aging and LGBT issues at the state and local level. LGBT issues need to be treated like a minority or disability element.

-James Bulot, Director, Georgia Department of Human Services, Division of Aging Services, Chair, NASUAD Board of Directors

Maui, Hawaii: Hawaii is a welcoming state, but during marriage equality debate, the dialogue was heart wrenching and it exemplified causes of isolation among LGBT elders. Even in a state as warm and welcoming as Hawaii, stigma and discrimination exists. Though Maui County has a HIV/AIDS program, there is no sense of what the LGBT community looks like. The County is trying to incorporate LGBT specific trainings, but barriers exist. In Hawaii, a common view is that we are all minorities so why does one specific demographic need special attention. More opportunities are needed for our citizens to tell their stories. Asking LGBT questions on all forms, starting at the federal level, is critical to increase visibility and to make informed decisions and will improve the experiences of LGBT older adults in Hawaii.

- Deborah Stone-Walls, Maui County Office on Aging

New York, New York: As an Area Agency on Aging (AAA) Director, it became obvious that training to raise awareness among mainstream population on the needs of LGBT elders was important. As a state agency, we adjusted our comprehensive assessment form to include LGBT questions to help collect data and use it to better serve the LGBT community. We also worked with local AAA that had concerns about asking LGBT related questions in culturally

competent ways and updated our annual implementation plan to include LGBT components and ensure those issues are included in the planning process for all programs. LGBT outreach is treated just like outreach to any other minority population. Inclusion in implementation plans is allowing the State to collect much more data on LGBT populations. To move ahead, leaderships on these issues need to start from top down. Every organization faces limited capacity and resources, which is why LGBT policies need to be put in place systemically to ensure equality. Advocates also have to stay the course to put pressure from the outside in and force us to collect the data and report back.

-Corinda Crossdale, New York State Office for the Aging

Religious Networks

Religious networks are also a source of social support among older LGBT adults. Fredriksen-Goldsen and colleagues (2011) found that 38% of older LGBT people attended a religious or spiritual service at least once a month. Religious service attendance differs by sexual orientation and gender identity, with bisexual older men more likely to attend service than gay older men, and transgender older adults more likely to attend service than cisgender LGB adults.

Although religiosity is related to better health in the general population (Ellison, 1991; Ellison et al., 2001), little empirical research exists about the effects of religious networks and LGBT older adults. One qualitative study of older LGBT adults in Chicago examined the quality and type of support LGBT older adults received from religious organizations (Brennan-Ing, Seidel, Larson & Karpiak, 2014). About 75% of 210 participants reported having some kind of religious affiliation and 38% reported that they have turned to their religious organization for support. Many of the respondents stated that they received not only emotional but also practical support, such as shopping and meal preparation, from their congregations. Though most respondents reflected positively on their religious affiliation and network, about 23% reported their sexual orientation and gender identity status negatively affected their religious association and reported using various coping mechanisms, such as changing churches or having less of a presence, to deal with the negative experiences. In general, LGB people are less religious than non-LGB people. White LGB people often switch their family religion to a more accommodating, gay-affirmative religion but this is less common for Black and Latino individuals. For Black and Latino LGB people, relationship with communities of color and church is significant for their sense of race/ethnic community identification and for maintaining social ties with their communities (Barnes & Meyer, 2012; Meyer & Ouellette, 2009).

Giving and Receiving Care

Given that LGB older adults are more likely than their heterosexual peers to live alone (Wallace, Cochran, Durazo & Ford, 2011), the role of primary caretaker often falls to families of choice (de Vries, 2011). Several studies have analyzed the extent to which LGB older adults have received or given care to others in their social network, particularly to other LGB older adults (Grossman et al., 2007; Shippy et al., 2004; Erosheva et al., 2015; Muraco & Fredriksen-Goldsen, 2011). In one study of LGB older adults in New York and Los Angeles, about 38% of respondents reported that they received care from someone other than a health-care provider in the past 5-years (Grossman, D'Augelli & Dragowski, 2007). Additionally, 65% of respondents reported they have *provided* care to another LGB older adult within the past 5-years (Grossman, D'Augelli & Dragowski, 2007).

In a study conducted in the Twin Cities Metropolitan Area of LGBT older adults, participants reported receiving primary care from a non-legal relation and were more likely to provide care to others they were not legally related to in the future (Croghan, Moone, & Olson, 2012). Other studies have found that between 21-27% of LGBT older adults reported they served as caregivers, of which close to 35% served a spouse and between 27-39% took care of a friend or non- related person (Fredriksen-Goldsen et al., 2011; Metlife, 2010). Sexual orientation and gender determine the likelihood of LGB older adults providing care to others: Females were more likely than males to provide care (Grossman et al., 2007), and bisexual women were more likely than lesbian women to provide care, though both bisexual and lesbian women were more likely to provide care than bisexual or gay men (Croghan et al., 2014). Lesbian and gay elders were also more willing to provide care to gay or lesbian older adults than they were to bisexual or heterosexual older adults (Grossman et al., 2007).

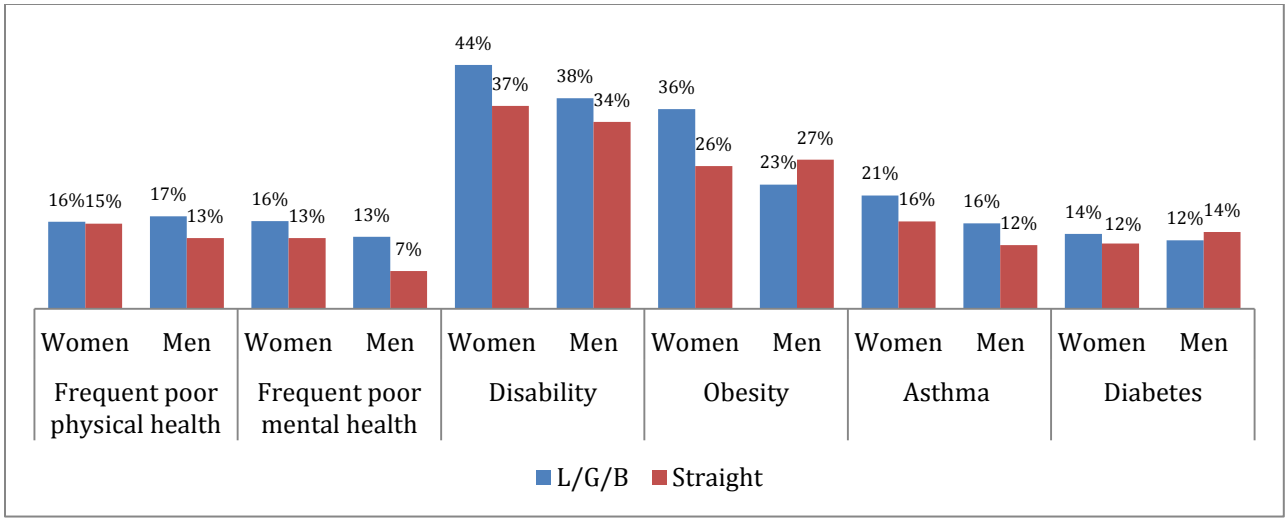
These results underscore the important role of families of choice and informal social networks as primary caretakers within the LGBT older adult population but also suggest that older LGBT adults may face extra burdens related to providing care to other older LGBT people (Muraco & Fredriksen-Goldsen, 2011). From a legal perspective, LGBT older adults who are the primary care for other LGBT older adults do not have the same state and federal privileges such as medical leave to care for a same-sex partner or medical decision-making processes for a terminally ill partner as heterosexual partners do (Krehely & Adams, 2010). Limited research is also available on the effect of caregiving among LGB older adults. Taking care of an older adult can be extremely taxing and burdensome. Muraco and Fredriksen-Goldsen (2011) examined the challenges LGB older adults face when caring for and receiving care from other LGB older adults. Through qualitative analysis of 18 care partners, the researchers found that relationships and boundaries were reevaluated and renegotiated as care receivers felt burdensome and care givers felt burdened. Expectations and social obligations to continue care are less clear for friends than they are for kin or spouses, adding complications and stress to the relationship of many LGB older adults (Barker et al. 2006). In fact, lesbian and gay older adults who provide

informal care and believe they will need support in the future from friends, have voiced a need for additional help in caring for other sexual minority older adults (Czaja et al, 2015). One study looked specifically at mid-life and older gay and lesbian caregivers' experiences after they provided care (Hash, 2008). As with any adult who has provided long-term care to a chronically ill spouse or friend, caregivers experienced loneliness, depression and physical and emotional strain. However, mid-life and older gay and lesbian caregivers also reported distress and difficulty in interactions with other forms of formal and informal support. For example, some respondents reported that ex-spouses or adult children were hostile or unaccepting of the caregiver or that health care providers refused to accept the caregiver as next-of-kin. Hash (2008) also reported incidents of caregivers dealing with whether to disclose or conceal the sexual identity of the care receiver and ultimately their own sexual orientation, upon death of the care receiver.

Health Outcomes

Compared to heterosexual older adults with similar demographic characteristics, sexual and gender minority older adults have worse mental and physical health (Fredriksen-Goldsen et al, 2013a; Addis et al., 2009; Fredriksen-Goldsen et al., 2011). LGB older adults have higher risks of mental health issues, disability, and higher rates of disease and physical limitations than heterosexual older adults (See Figure 1; Wallace et al., 2011; Fredriksen-Goldsen et al., 2013a). Below we examine studies on mental and physical health outcomes and determinants within the LGBT older population. However, most of the analysis compares health outcomes based on sexual orientation or gender identity, but do not classify different groups within LGBT populations and lack an intersectionality perspective.

Figure 1: Comparison of proportion of LGB and straight older adults' health outcomes, by gender and sexual orientation (Washington State BRFSS, 2003-2010)



*Source: Fredriksen-Goldsen et al., 2013a

Mental Health

Overall most LGBT older adults have rated their general mental health as good or satisfactory (D'Augelli, Grossman, Hershberger, & O'Connell, 2001; Fredriksen-Goldsen et al., 2011). However, when comparing overall mental health of LGB older adults with heterosexual older adults by gender, sexual minority adults have poorer mental health (Fredriksen-Goldsen et al., 2013a) and are more likely to have experienced psychological distress symptoms (Wallace et al., 2011). Though we do not have a comparison of transgender older adults' overall mental health with non-transgender older adults, we can examine differences within LGBT populations by sexual orientation and gender identity (Fredriksen-Goldsen et al., 2011). Bisexual older women reported a lower mental health score and showed a higher likelihood of frequent mental distress compared to lesbian women (Fredriksen-Goldsen, 2011; Fredriksen-Goldsen et al., 2010a). Bisexual older men also reported a lower mental health score than gay older men, and transgender older adults reported worse mental health than non-transgender adults (Fredriksen-Goldsen et al., 2011). Though the differences in perceived mental health disappeared when controlling for background characteristics for LGB older adults, they did not for transgender and cisgender LGB older adults (Fredriksen-Goldsen, 2011).

Research has measured the prevalence and factors that influence other mental health indicators such as depression, anxiety, and suicide ideation among the LGBT older adult population. Fredriksen-Goldsen and colleagues (2011) found that 31% of LGBT older adults reported depressive symptoms at a clinical level with transgender adults reporting the highest proportion of depressive symptoms. Similar results were also detailed in another study that compared transgender older adults with cisgender LGB older adults (Fredriksen-Goldsen et al., 2013b). In terms of suicide ideation, 39% of LGBT older adults reported they had at some point seriously considered taking their own life, with a higher proportion of transgender older adults (71%) reporting suicide ideation compared to cisgender LGB older adults (between 35-40%) (Fredriksen-Goldsen et al., 2011).

Mental health issues within the LGBT older population are linked to past experiences of victimization and discrimination, internalized stigma, barriers to health care, and poverty (Fredriksen-Goldsen, Emlet, Muraco, et al., 2012; D'Augelli & Grossman, 2001; Fredriksen-Goldsen et al., 2010). Among LGB older adults, victimization, internalized stigma, financial barriers to health care, and poor physical health were linked to depression (Fredriksen-Goldsen et al., 2013c). Experiences of victimization, particularly experiences of physical attack due to sexual orientation among LGB older adults, were associated with poorer mental health and more lifetime suicide attempts compared to adults who were not victimized or only verbally attacked (D'Augelli and Grossman, 2001). Difference in gender also exist, as gay and bisexual men who reported poor mental health reported higher levels of internalized homophobia, alcohol abuse, and suicide ideation than lesbian and bisexual women (D'Augelli et al., 2001). Suicidal behavior also seemed to differ by age range and is distributed across the lifespan among older adults with

the majority (69%) of suicide attempts occurring between ages 22-59, 27% at or before age 21, and 4% after age 60 (D'Augelli et al., 2001). In the same study, thirteen percent of the LGB older adult sample also reported a total 97 lifetime suicide attempts (Haas et al., 2011; D'Augelli et al., 2001). In turn, mental health problems are mitigated by protective factors such as social support (Fredriksen-Goldsen et al, 2013c). Ramirez-Valles et al (2014) found that fewer older gay men with support—e.g., they lived with another person and had a health care provider who knew of their sexual orientation—reported depressive symptoms as compared with peers with less support.

Physical Health

In general, LGBT older adults reported that they are in good physical health (D'Augelli, Grossman, Hershberger, & O'Connell, 2001; Fredriksen-Goldsen et al., 2011). Similar to mental health outcomes, there are some differences within LGBT older adults (Fredriksen-Goldsen et al., 2011). Bisexual older men and transgender older adults reported poorer overall physical health compared to gay older men and cisgender older adults, respectively. Results from a non-probability study showed that bisexual and lesbian women had similar levels of physical health (Fredriksen-Goldsen et al., 2011), but in probability sample comparing lesbian and bisexual women, Fredriksen-Goldsen and colleagues (2010a) found that bisexual women had poorer general health than lesbians.

Disability and health conditions among LGBT older adult populations have also been studied. About half of the participants in a study of over 2000 LGBT adults reported a disability and 44% reported they were they felt physically limited due to a physical, mental or emotional problem (Fredriksen-Goldsen et al, 2011). Comparing LGB older adults with heterosexual older adults, a higher proportion of LGB older adults reported a disability than heterosexual older adults (Fredriksen-Goldsen et al., 2013a) and older lesbian and bisexual women were 1.32 time more likely than heterosexual women to experience physical disability (Wallace et al., 2011).

Though many LGBT older adults self-report that they have good overall physical health, when comparing LGBT older adults with heterosexual older adults based on specific health outcomes, we find that both groups face similar health concerns and in some cases, LGBT older adults may be more at risk for certain health conditions compared to their non-LGBT counterparts. Obesity, high blood pressure, high cholesterol, asthma, cardiovascular disease and other health conditions are prevalent within the LGBT older adult population (Fredriksen-Goldsen et al, 2011). Two studies using representative samples provide some insight into how LGB older adults fare compared to heterosexual older adults. Within the Washington state population, Fredriksen-Goldsen and colleagues (2013a) find that lesbian and bisexual women are more likely to be obese than heterosexual women, while gay and bisexual men were less likely to be obese than heterosexual men. Lesbian and bisexual women also had higher risk for cardiovascular disease, and gay and bisexual men had higher risk for poor physical health compared to heterosexual older adults (Fredriksen-Goldsen et al., 2013a). Using data from a California probability sample

study, Wallace and colleagues (2011) found that although gay and bisexual men had similar rates of heart disease as heterosexual men, they had a higher ratio of hypertension, diabetes, psychological distress symptoms, and physical disability. The study did not find any statistical differences between sexual minority women and heterosexual women on key health conditions such as diabetes, hypertension, and heart disease.

Very little is known about transgender older adults and their physical health conditions. One study found that transgender older adults were at higher risk for poor physical health, disability, and depressive symptoms than non-transgender adults (Fredriksen-Goldsen et al., 2013b). Poor health outcomes were associated with gender identity, victimization and discrimination, lack of support, and health-related behaviors, though victimization and stigma explained poor health outcomes for most people.

HIV/AIDS

The HIV epidemic has had a profound impact on the LGBT population and continues to have a lasting impact on the older generation physically, emotionally, and psychologically (Friend, 1991; Emlet et al., 2015). While there are no national HIV prevalence data for older LGBT adults, Fredriksen-Goldsen and colleagues (2011) found that 9% of a nationally surveyed non-probability sample of LGBT older adults lived with HIV. Gay and bisexual men and transgender women, in particular, have high prevalence of HIV (Center for Disease Control, 2014; Herbst et al, 2008; Fredriksen-Goldsen, 2011). Furthermore, prevalence of HIV was higher for African Americans and Hispanics, compared to White LGBT older adults (Fredriksen-Goldsen et al. 2011). In a New York City study, the majority of LGB older adults living with HIV were White, followed by Latinos and African Americans (Karpiak & Brennan, 2009). Results of comparison analysis of HIV-positive LGBT older adults with HIV-negative LGBT older adults show that HIV positive older adults have worse mental and physical health, disability, poorer health outcomes (such as cardiovascular disease and rates of cancer), and a

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Social support for HIV positive seniors

HIV/AIDS programs and support networks for LGBT seniors are almost non-existent. This is true even in cities like Los Angeles, California where LGBT-specific centers and services are more common. Many elders do not think they can contract HIV and those that are HIV positive are heavily stigmatized. Given the lack of support and services, HIV positive LGBT seniors need to be taught spiritual, mental, and social tools, such as a buddy or referral system for newly diagnosed elders to function successfully.

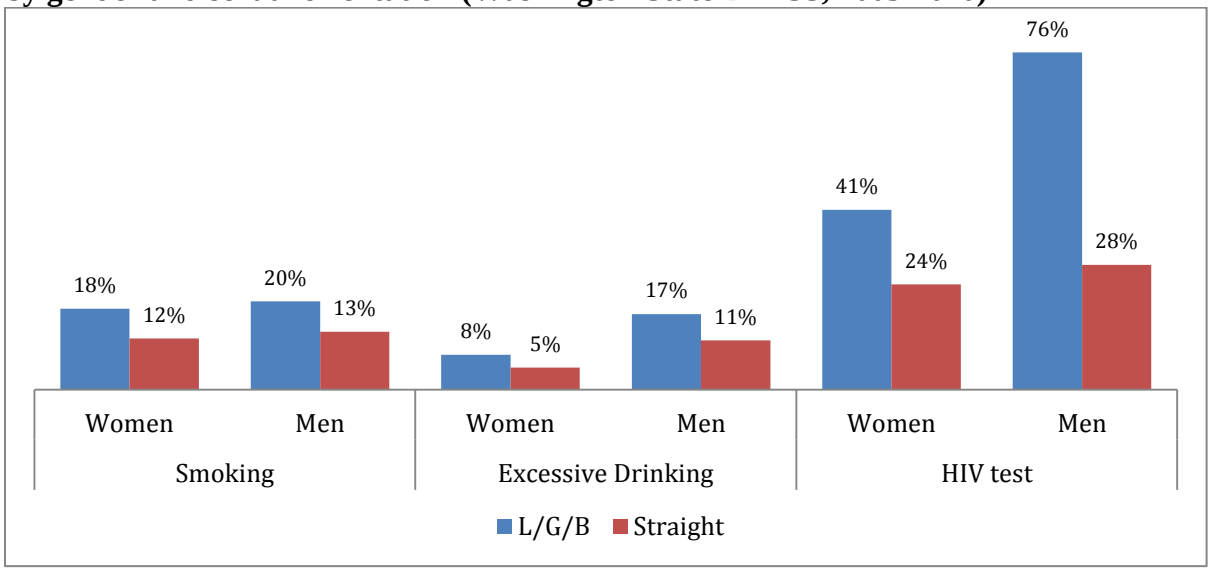
- Herbie Taylor, active member of L.A. LGBTQ Center

higher likelihood of experiencing stressors as well as barriers to care (Fredriksen-Goldsen et al., 2011). In particular, older gay men who are HIV positive experience multiple forms of stigma stemming from their sexual orientation, age, and HIV status and consequently report poor quality of life (Slater et al., 2015). Difficulties with finding social support and care are further exacerbated for many HIV positive LGBT older adults (Brennan-Ing et al., 2014; Shippy & Karpiak, 2005) and despite these additional challenges and fewer avenues for support, LGBT older adults living with HIV are often forgotten in discussions on LGBT and aging issues (Diverse Elders Coalition, 2014).

Health Behaviors

LGBT older adults also have a higher prevalence of engaging in risky health behavior, such as smoking and excessive alcohol consumption compared to heterosexual older adults (See Figure 2; Fredriksen-Goldsen et al., 2013a). Sexual minority women and men are more likely to smoke than their heterosexual counterparts (Fredriksen-Goldsen et al, 2013a). Some differences exist within the LGBT older population, as gay and bisexual men report higher levels of alcohol consumption than lesbian and bisexual women (Grossman, D'Augelli, & O'Connell, 2002). In another study, lesbian women reported higher rates of heavy drinking than bisexual women (Fredriksen-Goldsen et al., 2013c).

Figure 2: **Comparison of proportion of LGB and straight older adults' health behaviors, by gender and sexual orientation (Washington State BRFSS, 2003-2010)**



*Source: Fredriksen-Goldsen et al., 2013a

A high proportion of LGBT older adults also engaged in risky sexual behavior, with gay and transgender older adults reporting higher proportions of sexually risky behavior than bisexual men and sexual minority women (Fredriksen-Goldsen et al., 2011). On the other hand, LGBT older adults also reported higher rates of HIV testing, though between gay and bisexual men, bisexual men reported lower rates of being tested for HIV (See Figure 2; Fredriksen-Goldsen et

al., 2013c). Some studies looked specifically at sexually risky behavior among gay and bisexual men who reported HIV positive. A high proportion of HIV positive gay men and bisexual men reported engaging in sexually risky behavior (Golub et al., 2010; Emlet et al., 2015), and other health risks such as substance abuse were associated with sexually risky behavior (Brennan-Ing, Porter, Seidel, & Karpiak, 2014). Other studies found that internalized homophobia was associated with excessive drinking, drug use, and engagement in sexually risky behavior (Lelutiu-Weinberger et al., 2013; Emlet et al., 2015).

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Heterosexual framework impacts medical services for LGBT older adults

One common theme that emerged from the 2015 Denver convening was the challenge of finding trained, qualified, and culturally sensitive health providers. LGBT elders felt they were not represented within the healthcare system and that physicians still operated within a heterosexual framework. Many are not asked about their sexual orientation and assume patients are heterosexual. Some still operate under the idea that homosexuality is a mental illness: Pat Hussain, co-founder of GLAD in Atlanta, GA, recalled how a physician seeing a patient with PTSD asked "are you depressed because you are gay?" Pat advocates for training and materials to be updated in regards to LGBT older adult health issues. Troy Johnson of Senior Pride Initiative /Center of Halsted in Chicago brought to light how health services friendly to LGBT older adults are particularly scarce in the South and a major challenge for LGBT advocates is bridging the gap between the supply and demand of LGBT friendly service providers and LGBT older adults in need of care. Even among service providers who are interested in creating an LGBT friendly environment, mainstream service offerings are prioritized, according to Chris Kerr, Clinical Director of Montrose Center.

Health Services

Health services for LGBT older adults can be challenging as access and utilization of health services is complicated by fear of discrimination and poor treatment. In this section, we explore LGBT older adults and their attitudes about advanced-care or end-of-life care as well as the attitudes and experiences of providers who serve older adults.

Advanced-Care/ End-of-life Care

Fear and anxiety that LGBT older adults feel toward health care is further exacerbated in situations in which long-term care or advanced-care is needed (Brotman, et al., 2003; Stein, Beckerman & Sherman, 2010). Thus, older lesbians and gay men tend to delay entering residential care (Claes & Moore, 2000) and the majority believe health care providers would discriminate against them based on their sexual orientation (Johnson et al., 2005). Almost 75% of respondents in one study believed that residential

care facilities did not include anti-discrimination policies and 34% believed they would need to conceal their sexual orientation to live in the facility (Johnson et al, 2005). Other studies have recorded incidents of conflict and abuse of LGBT older adults in residential care due to displays of same-sex affection or of others' perception of residents' sexual minority status (Brotman et al., 2003; Bradford & Ryan, 1987). In fact, data from two qualitative studies of LGB older adults revealed a common concern of receiving long-term care was the fear of having to go back into the closet (Stein et al., 2010; Brotman et al, 2003). LGB older adults were also afraid of being neglected by their health care providers and of being ostracized by other residents due to their sexual orientation (Stein et al., 2010; Brotman et al., 2003).

To cope with this fear, many older LGB adults receiving long-term care reported that they conceal their sexual orientation for fear of mistreatment (Brotman et al, 2003). Possibly due to these stressors, one survey found that a higher proportion of LGBT adults reported wanting hospice care at home compared to heterosexual older adults (Metlife, 2010). Perhaps related to fear about old age care, in another study of lesbian and gay adults in New York City, a higher proportion of LG adults supported physician assisted suicide and palliative end of life care than did the heterosexual respondents, with most LG older adults over 60 preferring pain relief over life extension (Stein & Bonuck, 2001). Attitudes toward treatment at end-of-life, however, seemed more positive. Survey data results from two reports found that over 50% of the LGBT sample of older adults believed health professionals would treat them with respect at end-of-life (Metlife, 2010; Croghan, Moone, & Olson, 2012).

Provider Perspectives

Invisibility of LGBT elders was a theme voiced not only by LGB older adults receiving care but also by the providers and administrators providing senior health care (Brotman et al., 2003; Knochel, Croghan, Moone, & Quam, 2010). In a focus group study that included health administrators, Brotman and colleagues (2003) found that LGBT issues were avoided or ignored in agenda setting meetings. On the other hand, survey data assessing providers' readiness, attitudes, and experiences working with LGBT older adults in Michigan and the Midwest area showed that most providers were aware that LGBT older adults faced additional challenges from the general aging clientele and responded positively to providing or receiving training to work with LGBT older adults (Hughes, Harold & Boyer, 2011; Knochel, Croghan, Moone, & Quam, 2010). Providers believed their current services were appropriate for and environment welcoming toward LGBT older adults. However, almost half of the provider respondents in one survey reported that establishing separate services for LGB and T adults was not a good idea (Knochel, Croghan, Moone, & Quam, 2010). Additionally, few agencies reported that programs or efforts, such as outreach programs, existed to help LGBT older adults and few collected sexual orientation and gender identity demographics of their clientele. Agencies in urban areas or in the West had more requests for LGBT related services and more programs than did agencies in rural areas or the South (Knochel, et al., 2010).

The attitude and role of healthcare providers and organizations are integral to how services are sought and received. In a paper directed to health care providers and agencies, Fredriksen-Goldsen and colleagues (2014a) provided 10 core competencies to better serve the LGBT older adult population. Cultural competency was a major theme at both the provider and organization level with many of the recommendations focused on understanding the social history of LGBT individuals and conducting serious assessments of provider and organizational prejudices.

10 Core Competencies and Strategies to Providing Health and Human Services to LGBT Older Adults (Fredriksen-Goldsen et al., 2014)

1. Critically analyze personal and professional attitudes toward sexual orientation, gender identity and age, and understand how factors such as culture, religion, media, and health and human service systems influence attitudes and ethical decision-making
2. Understand and articulate the ways that larger social and cultural contexts may have negatively impacted LGBT older adults as a historically disadvantaged population
3. Distinguish similarities and differences within the subgroups of LGBT older adults, as well as their intersecting identities (such as age, gender, race, and health status) to develop tailored and responsive health strategies
4. Apply theories of aging and social and health perspectives and the most up-to-date knowledge available to engage in culturally competent practice with LGBT older adults
5. When conducting a comprehensive biopsychosocial assessment, attend to the ways that the larger social context and structural and environmental risks and resources may impact LGBT older adults
6. When using empathy and sensitive interviewing skills during assessment and intervention, ensure the use of language is appropriate for working with LGBT older adults to establish and build rapport
7. Understand and articular the ways in which agency, program, and service policies do or do not marginalize and discriminate against LGBT older adults
8. Understand and articulate the ways that local, state, and federal laws negatively and positively impact LGBT older adults, to advocate on their behalf
9. Provide sensitive and appropriate outreach to LGBT older adults, their families, caregivers and other supports to identify and address service gaps, fragmentation, and barriers that impact LGBT older adults
10. Enhance the capacity of LGBT older adults and their families, caregivers, and other supports to navigate aging, social, and health services

Future Research & Policy Needs

The growing population of LGBT older people is unique having experienced the spectrum of oppressive institutional stigma and discrimination in younger years, and unprecedented social change to understanding and acceptance of LGBT individuals in older adulthood. Still LGBT older adults are largely ignored in gerontology and sexual and gender minority research and by the agencies and stakeholder that serve these groups. Given the findings reported above, below are recommendations for future research and policy initiatives to deepen and broaden our understanding of LGBT older adults and address common barriers they face.

Research Needs

One of the biggest challenges to studying LGBT older adults is getting valid data. Most studies of LGBT older adults have used small sample sizes and community-based, non-probability sampling methods. While these studies have provided invaluable information, researchers, policy makers, and other stakeholders, findings from such studies are not generalizable to the overall LGBT older adult population (Addis et al. 2009). Policy makers who seek information from representative samples of LGBT older adults may find it difficult to characterize the population for several reasons. A prominent challenge is that sexual orientation and gender identity measures are not included in many U.S. probability-sampling based studies (Fredriksen-Goldsen et al., 2015). A second major challenge is that LGBT older adults are a small and, therefore, difficult population to reach. To achieve large enough number respondents, researchers who want to recruit probability samples would need to over-sample the LGBT older adult population (and, within this population, race/ethnic minorities). Such methods

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Recognizing diversity among LGBT older adults

Data collection, research, and developing data systems were important themes at the 2015 Denver convening. Researchers such as Drs. Karen Fredriksen-Goldsen, Naomi Goldberg, Ilan H. Meyer, and Samuel Haffer emphasized the lack of knowledge of disadvantaged communities within the LGBT older adult populations such as individuals living in poverty, people of color, individuals with disabilities, and other underserved groups. Ilan H. Meyer noted the need for NIH funding of population probability samples with large samples of LGBT individuals. Samuel Haffer, Director of Data and Policy Analytics Group at the U.S. Centers of Medicare & Medicaid Services (CMS) underlined how critical data collection is as the mindset among government agencies working with minority health populations is that if something cannot be measured, it cannot be improved. To improve data collection on LGBT individuals, CMS has established five major initiatives to integrate LGBT issues into the agency's data collection efforts. The initiatives aim to collect and analyze data in a standardized way at social and health service organizations that may serve LGBT older adults.

are costly and require larger funding sources than comparable studies of heterosexual cisgender populations. Despite these challenges, representative data are required for the study of health disparities because they allow comparison between LGBT and cisgender heterosexual older adults. Some recent policy changes are promising that LGBT older populations will be included in more federal and state surveys. Under the Obama administration, the Administration of Aging (now part of the Administration for Community Living) in the U.S. Department of Health and Human Services (HHS) stated in 2012 that the aging network has the discretion to consider LGBT older adults as a population of greatest social need (Tax, 2012). This could lead to increase attention and needed resources to the population of older LGBT adults.

Fredriksen-Goldsen & Kim (2015) found large surveys that include sexual orientation measurements often have a cut off age between age 50 and 60 for their samples because researchers incorrectly believe LGB older adults do not want to be studied and would not respond to surveys. Challenging this belief, Fredriksen-Goldsen & Kim (2015) reported that large numbers of LGB older adults were responding to questions and self-identifying with a minority sexual orientation and gender identity. (Although, the response rate was lower compared to that of younger LGB adults). Such limitations in data collection on LGB older adults may help explain why only two studies in this report used probability sampling data (both studies used state-level data) to characterize LGB older adults (Fredriksen-Goldsen et al 2013a; Wallace et al., 2011). To our knowledge, no probability sample data on transgender older adults exists. Despite this gap in knowledge, however, numerous studies using community-based sampling methods, reports, and reviews have provided important insight and knowledge about the lives of LGBT older adults and their shared challenges and resiliency.

Related to data collection and sample size, is the need to study subgroups within the population of LGBT older adults. Intersectionality perspective teaches us that there are important differences among intersectional subgroups, for example defined by gender and race/ethnicity, but knowledge about intersectional groups (e.g., older Black lesbians; Latina transwomen) is lacking. This can lead to misconceptions about a significant part of the LGBT elder population as policy makers assume that the knowledge gained from general, that is, mostly White LGBT populations, is representative of all subgroups of LGBT elders.

Bisexual and transgender older adults were particularly absent in many of the studies above. Even when studies and reports included bisexual older adults, their results were often folded in with results for gay and lesbian individuals. As bisexuals age, their sexuality may change to lesbian, gay, or straight, erasing their experience of aging (Dworkin, 2006) and leaving “no room for bisexuality within the older generation” (Kingston, 2002, p.4). Furthermore, bisexual older adults may experience different stressors compared to other sexual minorities as they are often stigmatized from both the heterosexual and homosexual communities (Dworkin, 2006).

Similarly, few studies include transgender older adults, and those that do use small sample sizes and conduct analysis on measures relevant to all LGBT older adults. There a serious lack of studies on the physical, psychological, and emotional process and effect of transitioning, an integral concept within the transgender community (Cook-Daniels, 2006). Similar to bisexual older adults, transgender older adults also face stigma from homosexual, heterosexual and gender-conforming communities (Cook-Daniels, 2006).

Another example of important subgroup analysis of LGBT older adults is age group-specific analysis (Czaja, 2015). In a recent study, Fredriksen-Goldsen and colleagues (2014) studied successful aging in the context of physical and mental health quality of life among LGBT older adults. Analysis was conducted by young-old (50-64), middle-old (65-79), and old-old (80 and older) groups. Results indicate that different factors influence quality of life by age group, with the most salient difference being that the effects of victimization and discrimination were most influential among the old-old group. Furthermore, factors that showed protective effects for the general LGBT older population, such as living with a partner, had a positive effect on the young-old and middle-old groups, but a negative effect on the old-old group (Fredriksen-Goldsen et al., 2014). Better understanding of different age groups could help policy makers and service agencies create more targeted interventions.

Life-course and intersectionality approaches to research would provide a more complete picture of the lived experiences of LGBT older adults (IOM, 2011). Though many life-course perspective studies have shown how historical and social context can affect LGBT older adults' health and general wellbeing (D'Augelli & Grossman, 2001; Fredriksen-Goldsen & Muraco, 2010), many gaps in knowledge remain. For example, little is known about chronic physical health, health outcomes measured through biomarkers, and cognitive health among LGBT older adults (Czaja, 2015). Longitudinal studies could help fill this knowledge gap as researchers can identify patterns over time and connections between determinants and outcomes can be better examined. Studies that take an intersectionality approach are even less available among LGBT older adults. The lived experiences of LGBT older adults who live in rural areas, are of different race/ethnicities, and are in lower socio-economic standing are particularly missing from the literature.

Finally, many areas studied in gerontology go unexamined among the LGBT older population. For example, little or no empirical research exists on family dynamics (older LGBT adults with children or grandchildren), caregiving patterns, workplace issues, bereavement and grief, cognitive health decline, mobility issues, chronic health issues, and program evaluations of health interventions among the LGBT older adult population.

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Lessons Learned from Serving LGBT Older Adults

- *Establishing public and private partnerships is key to providing comprehensive services to LGBT older adults. The Alzheimer's Association and American Association of Retired Persons (AARP) have been strong partners to the LGBT Center.*

  -Katheleen Sullivan, Director of Senior Services Department, L.A. LGBT Center, L.A., CA
- *Leadership on LGBT issues need to start from top down. Every organization faces limited capacity and resources, which is why LGBT policies need to be put in place systemically to ensure equality. We need to stay the course, collect data and report information to advocates.*

  - Corinda Crossdale, New York State Office for the Aging, New York, NY
- *Cultural competency and training seems to be an effective method to help service organization employees and providers overcome personal biases and stereotypes they may hold against LGBT individuals.*

  - James Bulot, Director, Georgia Department of Human Services, Division of Aging Services, Atlanta, GA
- *Aside from collecting and analyzing data, state funded organizations should be encouraged or mandated to look at results and take them into consideration when developing programs.*

  -Linda Levin, Executive Director, ElderSource, Jacksonville, FL
- *Raising awareness of LGBT older adults' unique issues is important. Many agencies do not believe LGBT older adults have unique barriers, story-telling, research, and information is critical to changing this dialogue.*

  -Deborah Stone-Walls, Maui County Office for the Aging, Maui, HI

Policy Needs

While research is important to increase our knowledge and educate policy makers and other entities involved with LGBT older adults, policy and program initiatives can provide more immediate and direct support and change (MAP & SAGE, 2010).

One major policy need is raising awareness and increasing advocacy about LGBT older adult needs and issues among LGBT and older adult service agencies and communities. LGBT older adults are part of both communities, yet many remain unaware of their needs (MAP & SAGE, 2010). Education and advocacy can instigate individuals and groups to develop targeted social service programs for LGBT older adults, funding for research, programs, and data collection, and formalize advocacy groups to represent LGBT older adults at different levels of government

(MAP & SAGE, 2010). Bringing visibility to these issues can also signal to LGBT older adults that organizations are welcoming and aware of their needs (Brotman et al. 2003).

At the federal level, an important overarching policy need is designating LGBT older adults as a population of "greatest social need" in the Older Americans Act (OAA) reauthorization. OAA is the biggest funding and service mechanism for older people in the U.S, yet few resources are designated specifically to LGBT older adults (Diverse Elders Coalition, 2014). Legal and administrative designation of LGBT older adults as a population of greatest social need would open important avenues for funding to prioritize LGBT older adults, and other subgroups that may experience additional forms of discrimination such as LGBT older adults of color and LGBT older adults living with HIV.

Other national policy recommendations include establishing legislation on anti-discrimination laws based on sexual orientation or gender identity and housing policy legislation to better protect LGBT older adults, particularly in healthcare, and access to retirement homes and senior centers. To help LGBT older adults adequately prepare for older life, expanding the definition of "family" to include families of choice and alternative family structures would be critical. Family structures are changing and broadening beyond the two-parent nuclear family structure and there are policy efforts to recognize these changes to include LGBT families and other family structures. Pertaining to paid sick leave for federal contractors the Department of Labor proposes that "[i]ndividual related by blood or affinity whose close association with the employee is the equivalent of a family relationship" means that any individual with a significant relationship with the employee is equivalent to family, regardless of biological or legal relationship (Executive Order No.13706, September 7, 2015). This broader definition of family would provide much needed time and support to LGBT older adults who provide care and receive care from families of choice. Finally, changing and implementing HIV testing guidelines to include adults over 65 and ensuring providers work with LGBT organizations to reach LGBT older adults who may have elevated levels of risk and are currently forgotten within the discussion of sexual health would be an important policy need (Diverse Elders Coalition, 2014).

At the service level, a major policy and program need is training of health professionals, agencies, and legal service providers to be culturally sensitive and knowledgeable of discriminatory practices or customs that overtly and inadvertently hurt LGBT older adults (MAP & SAGE, 2010; Fredriksen-Goldsen et al., 2014a). Given that fear of discrimination and actual discriminatory experiences have and continue to affect how LGBT older adults access and receive services, culturally sensitivity training may not be sufficient. Organizations and agencies should also consider instilling "anti-oppressive" practices—anti-oppressive practice recognizes structural inequalities and attempts to equalize power dynamics at an organization level (Preston-Shoot, 1995).

Another policy that service organizations can implement to help LGBT older adults is data collection of sexual orientation and gender identity measures of adults who utilize organization services. The feasibility of service organizations or service providers collecting sexual orientation and gender identity measures is highly debated, particularly in the healthcare setting (IOM, 2013; Cahill et al., 2016). Questions arise around provider competency and comfort in asking sexual orientation and gender identity questions, client's willingness to disclose such information, and even more damaging, whether simply asking about sexual orientation and gender identity would cause clients to delay or avoid healthcare (IOM, 2013). While examples of these situations exist, there are also many examples of healthcare service providers successfully collecting and storing sexual orientation and gender identity questions in electronic health record systems and of appreciation from LGBT individuals for being asked about their sexual and gender identity (IOM, 2013). Provider training, technical assistance from software vendors, and LGBT client training and education on why and how to best collect, store, and use LGBT data needs to happen for successful data collection by service organizations (Cahill et al., 2016; IOM, 2013). Though several measures to ensure confidentiality and remedy of disclosure would need to be in place to protect LGBT older adult identities, collecting service data can inform program managers and organizations of the prevalence and characteristics of LGBT older adults and their needs as well as identify any healthcare disparities based on sexual orientation or gender identity.

Finally, LGBT older adults need additional support systems. Many LGBT older adults may not have the time to wait for traditional service organizations to provide support (MAP & SAGE, 2010). Rather, policy makers need to think of alternative solutions to support this population. Programs such as "Share the Care", volunteer based networks composed of older adults' family, friends, neighbors or other informal networks who provide support during times of crisis, have proven helpful to many LGBT older adults (MAP & SAGE, 2010). Share the Care has been mobilized in small, non-urban areas that have a sizable number of LGBT people. Such support systems have provided intergenerational support to older adults (MAP & SAGE, 2010) and would allow the burden of caregiving to be shared among a larger community.

References

Addis, S., Davies, M., Greene, G., MacBride-Stewart, S., & Shepherd, M. (2009). The health, social care, and housing needs of lesbian, gay, bisexual and transgender older people: a review of the literature. *Health and Social Care in the Community, 17*(6), 647-658.

Administration on Aging. (2014). *Lesbian, Gay, Bisexual and Transgender (LGBT)*. U.S. Department of Health and Human Services, Administration for Community Living. Retrieved from: http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/diversity.aspx#LGBT

Alliance Healthcare Foundation. (2003). *The San Diego County LGBT Senior Healthcare Needs Assessment.*

Badgett, L., Lau, H., Sears, B. & Ho, D. (2007). *Bias in the workplace: Consistent evidence of sexual orientation and gender identity discrimination*. Los Angeles: Williams Institute. Retrieved from: http://williamsinstitute.law.ucla.edu/wp-content/uploads/Badgett-Sears-Lau-Ho-Bias-in-the-Workplace-Jun-2007.pdf

Barker, J.C., Herdt, G., & de Vries, B. (2006). Social support in the lives of lesbians and gay men at midlife and later. Sexuality Research & Social Policy: *Journal of NSRC. 3*(2):1–23.

Barnes, D.M. & Meyer, I.H. (2012). Religious affiliation, internalized homophobia, and mental health in lesbian, gay men, and bisexuals. *American Journal of Orthopsychiatry, 82*(3): 505-515.

Beeler, J. A., Rawls, T. W., Herdt, G., & Cohler, B. J. (1999). The needs of older lesbians and gay men in Chicago. *Journal of Gay and Lesbian Social Services, 9*, 31–49. 10.1300/J041v09n01_02

Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health, 103*(5), 943-51. doi:10.2105/AJPH.2013.301241

Bowleg, L. (2008). When Black + Lesbian + Woman ≠ Black Lesbian Woman: The methodological challenges of qualitative and quantitative intersectionality research. *Sex Roles, 59*. 312-325.

Bradford, J. B., & Ryan, C. (1987). *National Lesbian Health Care Survey: Mental health implications for lesbians*. Bethesda, MD: National Institute of Mental Health, National Technical Information Service, PB88-201496/AS.

Brennan-Ing, M., Seidel, L., Larson, B., & Karpiak, S.E. (2014). Social care networks and older LGBT adults: challenges for the future. *Journal of Homosexuality, 6*1(1), 21-52.

Brooks, K.D., Bowleg, L., Quina, K. (2009). Minority sexual status among minorities, In Loue S (Ed) *Sexualities and identities of minority women*. New York: Springer Science; pp. 41–63.

Brotman, S., Ryan, B., & Cormier, R. (2003). The health and social service needs of gay and lesbian elders and their families in Canada. *The Gerontologist, 43*(2), 192-202.

Brown, M.T. (2009). LGBT aging and rhetorical silence. Sexuality Research & Social Policy, *Journal of National Sexuality Resource Center, 6*(4). 65-78.

Cahill, S.R., Baker, K., Deutsche, M.B., Keatley, J., & Makadon, H.J. (2016). Inclusion of sexual orientation and gender identity in Stage 3 Meaningful Use Guidelines: A huge step forward for LGBT health. *LGBT Health, 3*(2). doi: 10.1089/lgbt.2015.0136

Cahill S., South K., & Spade J. (2000). *Outing age: Public policy issues affecting gay, lesbian, bisexual and transgender elders.* Washington, DC: National Gay and Lesbian Task Force

Cahill, S. & South, K. (2002). Policy issues affecting lesbian, gay, bisexual and transgender people in retirement. *Generations, 26*(2) Research Library. p. 49.

CenterLink & MAP (2016). *2016 LGBT Community Center Survey Report: Assessing the capacity and programs of lesbian, gay, bisexual, and transgender community centers*. CenterLink: The Community of LGBT Centers and Movement Advancement Project. Retrieved from: http://www.lgbtcenters.org/Data/Sites/1/SharedFiles/documents/news/2016-lgbt-community-center-survey-report.pdf

Centers for Disease Control and Prevention. (CDC). (2014). *HIV among gay and bisexual men.* Atlanta: CDC; Retrieved from: http://www.cdc.gov/hiv/risk/gender/msm/

Claes, J. A., & Moore, W. (2000). Issues confronting lesbian and gay elders: The challenge for health and human services providers. *Journal of Health and Human Services Administration, 23*(2), 181-202.

Cohler, B.J., & Hammack, P.L. (2007). The psychological world of the gay teenager: Social change, narrative, and "normality" *Journal of Youth and Adolescence, 36*(1):47–59

Cook-Daniels, L. (2006). Trans Aging. In Douglas Kimmel, Tara Rose, & Steven David (Eds.) *Lesbian, Gay, Bisexual and Transgender Aging: Research and Clinical Perspectives*. New York: Columbia University Press. 20-35

Cook-Daniels, L. (2015). Transgender Aging: What practitioners should know. In N.A. Orel & C.A. Fruhauf (Eds.) *The Lives of LGBT Older Adults: Understanding Challenges and Resilience.* American Psychological Association. 193-215.

Cook-Daniels, L., & munson, m. (2010). Sexual violence, elder abuse, and sexuality of transgender adults, age 50+: Results of three surveys. *Journal of GLBT Family Studies, 6,* 147-177.

Croghan, C.F., Moone, R.P., & Olson, A.M. (2012) *Twin Cities LGBT Aging Needs Assessment Survey*. Minneapolis: Greater Twin Cities United Way and PFund.

Croghan, C.F., Moone, R.P., Olson, A.M. (2014). Friends, family and caregiving among midlife and older lesbian, gay, bisexual, and transgender adults. *Journal of Homosexuality, 61*(1), 79-102.

Czaja, S. J. (2015). LGBT Older Adults: Experiences, Needs and Challenges. University of Miami Miller School of Medicine, Center on Aging: White Paper.

Czaja, S.J., Sabbag, S., Lee, C.C., Schulz, R., Lang, S., Vlahovic, T., Jaret, A., & Thurston, C. (2015). Concerns about aging and caregiving among middle-aged and older lesbian and gay adults. *Aging & Mental Health*, 1-12.

D'Addario, D. (June 12, 2016). The gay bar as safe space has been shattered. *Time*. Retrieved from: http://time.com/4365403/orlando-shooting-gay-bar-pulse-nightclub/

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

D'Augelli, A.R., Grossman, A.H., Hershberger, S.L., & O'Connell, T.S. (2001). Aspects of mental health among older lesbian, gay, and bisexual adults. *Aging and Mental Health, 5*(2), 149-158. DOI: 10.1080/13607860120038366

Dean, L., Wu, S., & Martin, J.L. (1992). Trends in violence and discrimination against gay men in New York City: 1984 to 1990. In G.M. Herek & K.T. Berrill (Eds.) *Hate crimes: Confronting violence against lesbians and gay men* (pp. 46-64). Newbury Park, CA: SAGE.

de Vries, B. (2009). Aspects of Life and Death, Grief and Loss in Lesbian, Gay, Bisexual and Transgender Communities in Kenneth J. Doka and Amy S. Tucci (Eds.), *Living with Grief: Diversity in End-of-Life Care*

de Vries, B. (2011). LGBT Aging: Research and Policy Implications. *Public Policy and Aging Report*. 21(3), 33-34

de Vries, B., Mason, A. M., Quam, J., & Acquaviva, K. (2009). State recognition of same-sex relationships and preparations for end of life among lesbian and gay boomers. *Sexuality Research & Social Policy, 6*(1), 90-91.

Diverse Elders Coalition. (2014). *Eight policy recommendations for improving the health and wellness of older adults with HIV*. Issue Brief. Diverse Elders Coalition. Retrieved from: http://www.diverseelders.org/wp-content/uploads/2014/05/DEC-HIV-and-Aging-Policy-Report_web.pdf

Dworkin, S.H. (2006). The aging bisexual, the invisible of the invisible minority. In Douglas Kimmel, Tara Rose, & Steven David (Eds.) *Lesbian, Gay, Bisexual and Transgender Aging: Research and Clinical Perspectives*. New York: Columbia University Press. 36-52.

Elder, G.H. (1998). The life course as developmental theory. *Child Development, 69*(1):1

Ellison, C.G. (1991). Religious involvement and subjective well-being. *Journal of Health and Social Behavior, 32*:80–99.

Ellison, C.G., Boardman, J.D., Williams, D.R., & Jackson, J.S. (2001). Religious involvement, stress, and mental health: Findings from the 1995 Detroit Area Study. *Social Forces, 80*:215–249.

Emlet, C.A., Fredriksen-Goldsen, K.I, Kim, H., & Hoy-Ellis, C. (2015). The relationship between sexual minority stigma and sexual health risk behaviors among HIV-positive older gay and bisexual men. *Journal of Applied Gerontology*, 1-22. doi:10.1177/0733464815591210

Equal Rights Center. (2014). *Opening Doors: An investigation of barriers to senior housing for same-sex couple*. Equal Rights Center. Retrieved from: http://www.equalrightscenter.org/site/DocServer/Senior_Housing_Report.pdf

Erosheva, E.A., Kim, H., Emlet, C., & Fredriksen-Goldsen, K.I. (2015). Social networks of lesbian, gay, bisexual, and transgender older adults. *Research on Aging*. Advance online access. doi: 0164027515581859

Executive Order No. 13706, 3 C.F.R. (September 7, 2015). Establishing Paid Sick Leave for Federal Contractors. Retrieved from: https://www.federalregister.gov/articles/2015/09/10/2015-22998/establishing-paid-sick-leave-for-federal-contractors. Accessed on July 22, 2016.

Frable, D.E., Platt, L., Hoey, S. (1998). Concealable stigmas and positive self-perceptions: Feeling better around similar others. *Journal of Personality and Social Psychology, 74*:909–922

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

Fredriksen-Goldsen, K.I., Kim, H., Barkan, S.E., Balsam, K.F., & Mincer, S.L. (2010a). Disparities in health-related quality of life: A comparison of lesbians and bisexual women. *American Journal of Public Health, 100*(11), 2255-2261.

Fredriksen-Goldsen, K. I., Kim, H.-J., Emlet, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C. P., Goldsen, J., Petry, H. (2011). *The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults*. Seattle: Institute for Multigenerational Health.

Fredriksen-Goldsen, K.I., Kim, H-J., Barkan, S.E., Muraco, A., Hoy-Ellis, C.P. (2013a). Health disparities among lesbian, gay, and bisexual older adults: Results from a population-based study. *American Journal of Public Health, 103*(10), 1802-1809.

Fredriksen-Goldsen, K.I., Cook-Daniels, L., Kim, H., Erosheva, E.A., Emlets, C.A., Hoy-Ellis, C.P., Goldsen, J. & Muraco, A., (2013b). Physical and mental health of transgender older adults: An at-risk and underserved population. *The Gerontologist, 54*(3), 488-500.

Fredriksen-Goldsen, K.I., Emlet, C.A., Kim, H., Muraco, A., Erosheva, E.A., Goldsen, J., & Hoy-Ellis, C.P. (2013c). The physical and mental health of lesbian, gay male, and bisexual (LGB) older adults: The role of key health indicators and risk and protective factors. *The Gerontologist, 53*(4), 664-675. doi:10.1093/geront/gns123

Fredriksen-Goldsen, K.I., Kim, H-J., Shiu, C., Goldsen, J. & Emlet, C.A. (2014). Successful aging amongst LGBT older adults: Physical and mental health-related quality of life by age group. *The Gerontologist, 00*(00). 1-15.

Fredriksen-Goldsen, K. I., Hoy-Ellis, C. P., Goldsen, J., Emlet, C. A., & Hooyman, N. R. (2014a). Creating a vision for the future: Key competencies and strategies for culturally

competent practice with LGBT older adults in the health and human services. *Journal of Gerontological Social Work*, 57, 80-107. doi: 10.1080/01634372.2014.890690

Fredriksen-Goldsen, K. I., & Kim, H.-J. (2015). Count Me In – Response to Sexual Orientation Measures Among Older Adults. *Research on Aging*, 37(5), 464-480. doi: 10.1177/0164027514542109

Friend, R. A. (1991). Older Lesbian and Gay People: A theory of successful aging. *Journal of Homosexuality, 20*(3-4), 99-118.

Frost, D.M. & Meyer, I.H. (2009) Internalized homophobia and relationship quality among lesbian, gay men and bisexuals. *Journal of Counseling Psychology, 56*(1), 97-109.

Frost, D. M., Meyer, I. H., & Schwartz, S. (2016). Social support networks among diverse sexual minority populations. *American Journal of Orthopsychiatry, 86*(1), 91-102. doi:10.1037/ort0000117

Gamson, J. & Moon, D. (2004). The sociology of sexualities: Queer and beyond. *Annual Review of Sociology, 30(*1):47–64

Gates, G. & Newport, R. (2015). *Special Report: 3.4% of U.S. Adults Identify as LGBT*. Gallup. Retrieved from: http://www.gallup.com/poll/158066/special-report-adults-identify-lgbt.aspx

Gay, Lesbian, and Straight Education Network.(GLSEN). (1999). *GLSEN's national school climate survey: Lesbian, gay, bisexual and transgender students and their experiences in school*. New York: Author

Goldberg, N.G. (2009). *The Impact of Inequality for Same-Sex Partners in Employer-Sponsored Retirement Plans.* Los Angeles: The Williams Institute.

Golub, S. A., Tomassilli, J. C., Pantalone, D. W., Brennan, M., Karpiak, S. E., & Parsons, J. T. (2010). Prevalence and correlates of sexual behavior and risk management among HIV-positive adults over 50. *Sexually Transmitted Diseases, 37*, 615-620. doi:10.1097/OLQ.0b013e3181e15f20

Grant, J.M., Mottett, L.A., & Tanis, J. Harrison, J., Herman, J.L., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey.* Washington: National Center for Transgender Equality & National Gay & Lesbian Task Force.

Grossman, A.H., D'Augelli, A.R., & Hershberger, S.L. (2000). Social Support Networks of Lesbian, Gay, and Bisexual Adults 60 Years of Age and Older. *Journal of Gerontology, 55B*(3), 171-179.

Grossman, A.H., D'Augelli, A.R., & O'Connell, T.S. (2002). Being lesbian, gay, bisexual, and 60 or older in North America. *Journal of Gay & Lesbian Social Services, 13*(4), 23-40. DOI: 10.1300/J041v13n4_05

Grossman A.H., D'Augelli, A.R., & Dragowksi, E.A. (2007). Caregiving and care receiving among older lesbian, gay, and bisexual adults. *Journal of Gay & Lesbian Social Services, 18(*3-4), 15-38. DOI: 10.1300/J041v18n03_02

Grossman, A.H. (2008). Conducting research among older lesbian, gay, and bisexual adults. *Journal of Gay & Lesbian Social Services, 20*(1-2). 51-67.

Haas, A.P. Eliason, M., Mays, V.M., Mathy, R.M., Cochran, S.D., D'Augelli, A.R., et al (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations. *Journal of Homosexuality, 58* (10-51). Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3662085/pdf/wjhm58_10.pdf

Harrison, A.E. & Silenzio, V.M. (1996). Comprehensive care of lesbian and gay patients and families. *Primary Care, 23*(1), 31-46.

Hash, K. (2008). Caregiving and Post-Caregiving Experiences of Midlife and Older Gay Men and Lesbians. *Journal of Gerontological Social Work, 47*(3-4), 121-138.

HHS (U.S. Department of Health and Human Services). (2000). *Healthy people 2010: Understanding and improving health*. Washington, DC: HHS.

HHS. (2001). *Lesbian, gay, bisexual, and transgender health*. Retrieved from: http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25.

Hendricks, M. & Testa, R.J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Research and Practice, 43*(5), 460-467.

Herbst JH, Jacobs ED, Finlayson TJ, et al. (2008). Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. *AIDS Behavior,12,*:1-17.

Herek, G.M. (2009) Hate crimes and stigma-related experiences among sexual minority adults in the United States: Prevalence estimates from a national probability sample. *Journal of Interpersonal Violence, 24*, 54-74.

Herek, G.M., Gillis, J.R., & Cogan, J.C. (1999). Psychological sequelae of hate crime victimization among lesbian, gay, and bisexual adults. *Journal of Consulting and Clinical Psychology, 67*(6), 945-951.

Herek, G.M., Gillis, J.R., Cogan, J.C., & Glunt, E.K. (1997). Hate crime victimization among lesbian, gay, and bisexual adults: Prevalence, psychological correlates, and methodological issues. *Journal of Interpersonal Violence, 12*, 195-215.

Herek, G.M., Gillis, J.R., & Cogan, J.C. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology, 56*(1): 32-43.

Hoy-Ellis, C.P., & Fredriksen-Goldsen, K.I. (2016). Lesbian, gay, & bisexual older adults: Linking internal minority stressors, chronic health conditions, and depression. *Aging and Mental Health.* doi: 10.1080/13607863.2016.1168362

Hughes, A.K., Harold, R.D., & Boyer, J.M. (2011). Awareness of LGBT aging issues among aging services network providers. *Journal of Gerontology & Social Work, 54*(7): 659-677.

Institute of Medicine. (2011). *The health of lesbian, gay, bisexual and transgender people: Building a foundation for better understanding*. The National Academies of Sciences, Engineering, Medicine.

Institute of Medicine (2013). *Collecting sexual orientation and gender identity data in electronic health records: Workshop summary*. Washington, D.C.: The National Academies Press.

Jacobs RJ, Rasmussen LA, Hohman MM. (1999). The Social Support Needs of Older Lesbians, Gay Men, and Bisexuals. *Journal of Gay and Lesbian Social Services, 9*(1):1–30.

Johnson M, Jackson N, Arnette J, Koffman S. 2005. Gay and lesbian perceptions of discrimination in retirement care facilities. *Journal of Homosexuality*. 49:83-102.

Karpiak & Brennan (2009). The emerging population of older adults with HIV and introduction to ROAH the research study. In Mark Brennan, Stephen E. Karpiak, R. Andrew Shippy & Marjorie H. Cantor (Eds.) *Older Adults with HIV: An in-depth examination of an emerging population.* New York: Nova Science Publishers, Inc. 11-22.

Kim, H.-J., & Fredriksen-Goldsen, K. I. (2014). Living Arrangement and Loneliness Among Lesbian, Gay, and Bisexual Older Adults. *The Gerontologist.* Advance online access. doi: 10.1093/geront/gnu083

Kimmel, D., Rose, T., & David, S. (2006). *Lesbian, Gay, Bisexual and Transgender Aging: Research and clinical perspectives*. New York: Columbia University Press.

Kimmel, D., Rose, T., Orel, N., & Greene, B. (2006). Historical context for research on lesbian, gay, bisexual and transgender aging. In Douglas Kimmel, Tara Rose, & Steven David (Eds.) *Lesbian, Gay, Bisexual and Transgender Aging: Research and Clinical Perspectives*. New York: Columbia University Press. 1-19.

Kingston, T. (2002). "You have to speak up all the time": Bisexual elders address issues, concerns of aging. *Outword, 8*, 4-5.

Knochel, K.A., Croghan, C.F., Moone, R.P., Quam, J.K. (2010). *Ready to Serve? The Aging network of LGB and T older adults*. Retrieved from: http://www.lgbtagingcenter.org/resources/pdfs/ReadyToServe.pdf

Krehely, J. & Adams, M. (Sept 28, 2010). *Protecting our LGBT Elders: an overview of LGBT Aging issues. Center for American Progress*. Retrieved on April 22, 2016. Retrieved from: https://www.americanprogress.org/issues/lgbt/report/2010/09/28/8411/protecting-our-lgbt-elders/

Laditka, S.B., Corwin, S.J., Laditka, J.N., Liu, R., Tseng, W., Wu, B., et al. (2009). Attitudes about aging well among a diverse group of older Americans: Implications for promoting cognitive health. *Gerontologist, 49* (suppl.1) S30-S39.

Lang, N. (June 13, 2016). Call the Orlando massacre a hate crime: This was an attack on the LGBT community—and that matters. *Salon*. Retrieved from: http://www.salon.com/2016/06/13/call_the_orlando_massacre_a_hate_crime_this_was_an_attack_on_the_lgbt_community_and_that_matters/

Lelutiu-Weinberger, C., Packankis, J. E., Golub, S. A., Walker, J. J., Bamonte, A. J., & Parsons, J. T. (2013). Age cohort differences in the effects of gay related stigma, anxiety and identification with the gay community on sexual risk and substance use. *AIDS and Behavior, 17*, 340-349. doi:10.1007/s10461-011-0070-4

LGBT Movement Advancement Project & Services and Advocacy for Gay, Lesbian, Biseuxal and Transgender Elders (MAP & SAGE). (2010). *Improving the lives of LGBT older adults.* http://www.lgbtmap.org/file/improving-the-lives-of-lgbt-older-adults.pdf

Marriage Equality FAQ: Frequently asked questions about the Supreme Court's Marriage Ruling. *Social Security Spousal Benefits*. Retrieved from: https://marriageequalityfacts.org/topic/social-security-spouse/ Accessed on July 22, 2016.

Masini, B. E. & Barrett, H. A. (2008). Social support as a predictor of psychological and physical well-being and lifestyle in lesbian, gay, and bisexual adults aged 50 and older. *Journal of Gay & Lesbian Social Services, 20*(1-2), 91-110.

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

McLeroy, K.R., Bibeau, D., Steckler, A., Glanz, K.(1988). An ecological perspective on health promotion programs. *Health Education Quarterly.15*(4):351–377.

Metlife Mature Market Institute, & American Society on Aging (2010). *Still out, still aging: The Metlife study of lesbian, gay, bisexual, and transgender baby boomers*. New York: Metlife Mature Market Institute and American Society on Aging; Retrieved from: http://www.metlife.com/mmi/research/still-out-still-aging.html#findings

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

Meyer, I.H. (2001).Why lesbian, gay, bisexual, and transgender public health? *American Journal of Public Health, 91*:856–859

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674-697.

Meyer, I. H. (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity, 2*(3), 209-213. doi:10.1037/sgd0000132

Meyer, I.H. & Dean, L. (1998). Internalized homophobia, intimacy, and sexual behavior among gay and bisexual men. In: Herek GM, editor. *Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals*. Thousand Oaks, CA: Sage.

Meyer, I. H., & Ouellette, S. C. (2009). Unity and purpose at the intersections of racial/ethnic and sexual identities. In P. L. Hammack & B. J. Cohler (Eds.), *The story of sexual identity: Narrative perspectives on the gay and lesbian life course* (pp. 76-106). New York, NY: Oxford University Press.

Meyer, I.H., Schwartz, S., & Frost, D.M. (2008). Social patterning of stress and coping: Does disadvantaged social statuses confer more stress and fewer coping resources? *Social Science & Medicine, 67*(3). 368-379. doi:10.1016/j.socscimed.2008.03.012

Meyer, I. H., & Wilson, P. A. (2009). Sampling lesbian, gay, and bisexual populations. *Journal of Counseling Psychology, 56*(1), 23-31. doi:10.1037/a0014587

Michigan Fair Housing Centers (2007). *Sexual orientation and housing discrimination in Michigan: A report of Michigan's Fair Housing Centers*. Fair Housing Center of Southeastern Michigan. Retrieved from: http://www.fhcmichigan.org/images/Arcus_web1.pdf

Moore, H.A., Acosta, K., Perry, G. & Edwards, C. (2010). Splitting the Academy: The emotions of intersectionality at work. *The Sociological Quarterly, 51*. 179-204.

Morrow, D.F. (2001). Older gays and lesbians: Surviving a generation of hate and violence. *Journal of Gay & Lesbian Social Services, 13*(1-2). 151-169.

Muraco, A., & Fredriksen-Goldsen, K. I. (2011). That's what friends do: Informal caregiving for chronically ill midlife and older LGB adults. *Journal of Social and Personal Relationships, 28*(8), 1073-1092. doi: 10.1177/0265407511402419

National Institutes of Health Sexual and Gender Minority Research Coordinating Committee. (2016). *NIH FY 2016-2020 Strategic Plan to Advance Research on the Health and Well-being of Sexual and Gender Minorities*. National Institutes of Health. Retrieved from: https://dpcpsi.nih.gov/sites/default/files/sgmStrategicPlan.pdf

Pachankis, J.E. (2007). The psychological implications of concealing a stigma: a cognitive-affective-behavioral model. *Psychological Bulletin, 133*(2), 328-345.

Pew Research Center. (2013). *A Survey of LGBT Americans: Attitudes, experiences and values in changing times.* Retrieved from: http://www.pewsocialtrends.org/2013/06/13/a-survey-of-lgbt-americans/

Phelan, E.A., Anderson, L.A., LaCroix, A.Z. & Larson, E.B. (2004). Older adults' views of "successful aging"—How do they compare with researchers' definitions? *Journal of the American Geriatrics Society, 52*(5), 211-216.

Potter, J., Goldhammer, H., & Makadon, H. (2008). *Clinicians and the Care of Sexual Minorities*. Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health, 3-24.

Preston-Shoot, M. (1995). Asessing anti-oppressive practice. *Social Work Education, 14*(2). 11-29.

Quam J.K. & Whitford G.S. (1992). Adaptation and Age-Related Expectations of Older Gay and Lesbian Adults. *The Gerontologist, 32*:367–375.

Ramirez-Valles, J., Dirkes, J., & Barrett, H.A. (2014). Gayby Boomers' Social Support: Exploring the Connection Between Health and Emotional Instrumental Support in Older Gay Men. *Journal of Gerontological Social Work, 57*(2-4), 218-234.

Rosenfeld D. (1999). Identity work among lesbian and gay elderly. *Journal of Aging Studies.* Vol. 13. Elsevier Science Publishing Company, Inc; p. 121

Russell, S. T., Ryan, C., Toomey, R. B., Diaz, R. M., & Sanchez, J. (2011). Lesbian, gay, bisexual, and transgender adolescent school victimization: Implications for young adult health and adjustment. *Journal of School Health, 81*(5), 223-230. doi:10.1111/j.1746-1561.2011.00583.x

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics, 123*(1), 346-52. doi:10.1542/peds.2007-3524

Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child Adolescent Psychiatric Nursing, 23*(4), 205-13. doi:10.1111/j.1744-6171.2010.00246.x

Safe Schools Coalition of Washington.(1999). *Eighty-three thousand youth: Selected findings of eight population-based studies as they pertain to anti-gay harassment and the safety and well-being of sexual minority students*. Seattle, WA: Author.

SAGE and Hunter College Brookdale Center. (1999*). Assistive Housing for Elderly Gays and Lesbians in New York City.*

SAGE (November 17, 2015). Notes from Evaluating and Enhancing Aging Network Outreach to LGBT Older Adults. Denver, Colorado Convening.

Shippy, R.A., Cantor, M.J., Brennan, Mark (2004). Social networks of aging gay men. *The Journal of Men's Studies, 13*(1), 107-120.

Shippy, R.A. & Karpiak, S.E. (2005). The aging HIV/AIDS population: Fragile social networks. *Aging & Mental Health, 9*(3), 246-254.

Silliman R. A., 1986. Social stress and social support. *Generations 10*: (3) 18-20.

Slater, L. Z., Moneyham, L., Vance, D.E., Raper, J.L., Mugavero, M.J., & Childs, G. (2015). The multiple stigma experience and quality of life in older gay men with HIV. *Journal of Association of Nurses AIDS Care, 26*(1): 24-35.

Stein, G.L., Beckerman, N.L., & Sherman, P.A. (2010). Lesbian and gay elders and long-term care: identifying the unique psychosocial perspectives and challenges. *Journal of Gerontology of Social Work, 53*(5), 421-35.

Stein, G. & Bonuck, K. (2001). Attitudes on end-of-care and advance care planning in the lesbian and gay community. *Journal of Palliative Medicine, 4*(2), 173-190.

Tax, A. (2012). Federal Update: LGBT populations and "Greatest Social Need". Services and Advocacy for GLBT Elders. Retrieved from: http://www.lgbtagingcenter.org/resources/resource.cfm?r=544

Testa, R. J., Habarth, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the gender minority stress and resilience measure. *Psychology of Sexual Orientation and Gender Diversity, 2*(1), 65-77. doi:10.1037/sgd0000081

Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology, 46*(6), 1580-9. doi:10.1037/a0020705.

U.S. Department of Housing of Urban Development (2015). *Program Eligibility in Multifamily Assisted and Insured Housing Programs in Accordance with HUD's Equal Access Rule*. Retrieved from: http://portal.hud.gov/hudportal/documents/huddoc?id=15-06hsgn.pdf

U.S. Equal Employment Opportunity Commission. *What you should know about EEOC and the enforcement protections for LGBT workers.* Retrieved from*:* https://www.eeoc.gov/eeoc/newsroom/wysk/enforcement_protections_lgbt_workers.cfm. Accessed on July 18, 2016.

Van Wagenen, A., Driskell, J., Bradford, J. (2013). "I'm still raring to go": Successful aging among lesbian, gay, bisexual, and transgender older adults. *Journal of Aging Studies, 27,* 1-14.

Wallace S., Cochran S., Durazo E., Ford C. (2011). *The health of aging lesbian, gay and bisexual adults* in *California*. Los Angeles: UCLA Center for Health Policy Research.

Weston, K. (1991). *Families we choose: Lesbians, gays, kinship*. New York: Columbia University Press

White, A.M., Philogene, G.S., Fine, L., & Sinha, S. (2009). Social support and self-reported health status of older adults in the United States. *American Journal of Public Health, 99,* 1872-1878.

Wight, R. G., LeBlanc, A. J., de Vries, B., & Detels, R. (2012). Stress and mental health among midlife and older gay-identified men. *American Journal of Public Health, 102*(3), 503 - 510.

Wight, R. G., LeBlanc, A. J., Meyer, I. H., & Harig, F. A. (2015). Internalized gay ageism, mattering, and depressive symptoms among midlife and older gay-identified men. *Social Science & Medicine, 147,* 200-208. doi:10.1016/j.socscimed.2015.10.066

Williamson I. (2000). Internalized homophobia and health issues affecting lesbians and gay men. *Health Education Research, 15*:97–107.

Zambelich, A. & Hurt, A. (June 26, 2016). 3 hours in Orlando: Piecing together an attack and its aftermath. *National Public Radio.* Retrieved from: http://www.npr.org/2016/06/16/482322488/orlando-shooting-what-happened-update

Zians, J. (2011). *LGBT San Diego's Trailblazing Generation: Housing and related needs of LGBT Seniors.* The San Diego Lesbian, Gay, Bisexual & Transgender Community Center