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# LGBT Aging and Elder Care

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LGBT Aging and Elder Care

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## Abstract

This project focuses on particular issues faced by elderly lesbian, gay, bisexual and transgendered (LGBT) people. This qualitative study involves interviews with eight gay men, four lesbians and two service providers and seeks to understand the unique challenges confronting aging members of the LGBT community and the quality of training received by caregivers assisting this population. Interview participants included three couples and four single men, and two partnered individuals across Massachusetts and Rhode Island. Analysis of the data indicates that the areas of greatest concern to LGBT elders are social-support networks and broader social change. Individuals interviewed expressed concern about maintaining local connections or receiving support within the direct community, while couples were primarily concerned with legal rights on a federal level, such as spousal benefits and pension transference. Services providers expressed concern about understaffed agencies, a void in LGBT elder training and lack of agency support in meeting the needs of this minority group. Aging members of the LGBT community who have faced stigmatism, discrimination or marginalization throughout their life would benefit from an environment that supports diversity and institutional changes designed to meet their distinctive needs. Policy-makers interested in equal protection, eldercare advocates or diversity awareness groups could utilize these findings.

*Key Words: LGBT, elders, social supports, legal rights, and health care.*

Our communities are rapidly aging. According to the World Health Organization, the population of adults aged 60 years and older will triple by the year 2050 (Imbody and Vansburger, 2011) and the number of older Americans living in the United States will be over 2 billion (Sade, 2012). This rapid population increase of older adults goes by several names, including the silver tsunami, the geriatric imperative or the age wave, among others. The aging baby boomer cohort, those born between 1946 and 1964, is swelling this particular group of Americans and soon seventy-six million aging boomers will enter the fragmented and underfunded health care arena. From solely a health care perspective, these numbers are daunting (Delafuente, 2009). In addition to the concerns of all people as they grow older, such as declining physical strength or mental health, loss of independence, difficulties with social integration and inclusion, there is an increased risk of social and emotional isolation by belonging to an overlooked minority group that is left out of program planning and aging services (Brown and Cocker, 2011).

The Lesbian, Gay, Bisexual and Transgendered (LGBT) population is frequently marginalized, often disregarded and still regularly faces openly prejudiced or bigoted attitudes (Cook-Daniels, 2011). As with any aging member of our population, LGBT elders deserve to age with dignity and respect in an environment that is safe, affordable and culturally sensitive, while simultaneously treating the health of the entire individual, regardless of sexual orientation. By assuming heterosexuality, healthcare organizations, groups and providers continue to force aging members of the LGBT community back into the shadows, denying their existence (Morrow, 2001). Often, this group of aging adults does not have their specific, distinctive needs met which negatively impacting life opportunities, wellbeing and health-related aging (Huges, 2009). In addition to the concerns of all people as they grow older, such as declining health, physical and

mental acuity, independence, and the ability to integrate and enhance social inclusion (Sade, 2012), there is an increased risk of social and emotional isolation for LGBT elders (Apuzzo, 2001). The effectiveness of providing a culturally sensitive environment that meets the unique needs of the older LGBT community is complex at best. This project seeks to understand the unique challenges confronting aging members of the LGBT community and the quality of training received by caregivers assisting this population.

As the LGBT community ages, many members are forced into hiding, denied services and left to die alone because of discrimination, stigmatism or hatred (Morrow, 2001). Given that many federal, state and local levels do not include specific information on LGBT elders, this institutionalized form of social discrimination inhibits most LGBT elders of availing themselves of services on which other seniors thrive (Brown & Cocker, 2011). Many retreat back into the closet, reinforcing the isolation of a people whose experiences, families, communities, histories and even moral worthiness have been stigmatized (Cahill, South & Spade, 2000). Despite historical and contemporary oppression, members of the LGBT elder community have been at the forefront of sweeping societal changes related to gender identity and sexual orientation (Morrow, 2001). Haber (2009) uses two major historical events to substantiate the position that the LGBT community will have an impact on aging and elder care: the Stonewall Inn Riots and the reversal of the declaration that homosexuality is a psychosis or labeled as a mental illness. While Stonewall was not the first pushback from the gay community against government-sponsored persecution, it was a galvanizing point for gay and lesbian culture, signifying a change from a passive to active resistance in response to institutionalized anti-gay violence (Morrow, 2001). With the changes made to the Diagnostic and Statistical Manual of Mental Disorders (DSM), the scientific community no longer declared being gay a mental illness (Ford, 2012).

Changes made to the attitudes towards members of this minority group were a direct result of advocacy and social action by members of the LGBT community (Morrow, 2001).

### **Literature Review**

This research study seeks to understand the barriers facing aging members of the LGBT community and the role social worker's play in effectively meeting the needs of this population. This literature review focuses on the lives and experiences of LGBT elders. The group known as the "baby boomer" generation is fueling the expansion of older adults. The beginning waves of the 76 million strong baby boomer cohort turned 65 in 2011, nearing retirement, demanding attention and poised to forever revolutionize retirement and aging (Sade, 2012).. This cohort is accustomed to changing the way agencies provide services, products are sold and what constitutes acceptance in society (Haber, 2009). This group of older adults was the product of peacetime security after World War II, yet lived through many significant world events. They saw the first lunar landing, the Vietnam War, an assassination of a President of the United States, the Civil Rights Movement, political turmoil, the Cold War and spiritual, religious and moral upheaval (Sade, 2012). According to Haber (2009), the baby boomer cohort has a history of making societal changes throughout its lifecycle, including changes to hospitals, healthcare and the early child development institutions that needed to change to support the sheer size of this collective group. Creating a similar shift in public schools and the housing market, this group also influenced public policy. They took leadership positions in the Civil Rights Movement, influenced the direction of the war in Vietnam and the brought dynamic changes to business and corporate structures (Haber, 2009).

As life expectancy rates continue to rise, estimates indicate that by the year 2030 70 million older persons, those aged sixty-five or older, will be living in the United States (Delafuente, 2009). Those numbers represent almost twenty percent of the total United States population (Landers et al., 2010). More importantly, these estimates include a significant number of aging LGBT Americans. While fear of discrimination, stigmatism, prejudice or marginalization prevent many older adults from openly identifying as members of the LGBT community, it is safe to assume that the percentage of older adults that are LGBT should mimic the percentage of population numbers for younger Americans (Landers et al, 2010).

As with other marginalized communities, LGBT older adults face significant barriers and profound disparities that place them in great social need (Anetzberger et al., 2004). Many federal, state and local levels do not include LGBT-specific programs for older adults and do not collect LGBT-specific data, creating a void of comprehensive information about the lifetime effects of discrimination, stigma and violence (Brown & Cocker, 2011). How will the needs of this minority group be met to avoid the effects of social discrimination and barriers such as poverty, social isolation and delayed care seeking, if the LGBT-specific data is not collected? Incomplete or inaccurate demographic knowledge about LGBT elders, including the number of low-income elders, numbers of same-sex couples aging together, and the number who have raised children or are currently raising children makes it difficult for advocates to represent this population (Brown & Cocker, 2011). Devoid of this valuable data, policy discussions within the Department of Health and Human Services or the Social Security Administration cannot fully account for the lives and needs of LGBT elders (Apuzzo, 2001). LGBT seniors are twice as likely to age single, more than twice as likely to live alone and more than four times as likely not to have children to call upon in times of need as compared to heterosexual elders (Gabrielson, 2011). Due to these

increased needs, LGBT elders require more social services and supports to age successfully (Cook-Daniels, 2011).

Anetzberger et al, (2004), note that LGBT elders have fewer sources of societal and family supports when compared to their heterosexual peers. They also face higher poverty rates, experience higher incidences of poor health and experience limited access to health services. Issues such as financial security and income throughout aging, unexpected debilitating illness, economic hardship, and loss of friends and family are difficult to anticipate or navigate (Cook-Daniels, 2011). Potentially, every older adult may face these issues, but LGBT seniors face specific challenges that are directly related to, and often caused by, their unique minority status (Landers, et al., 2010). Aging members of the LGBT community often face changes and upheaval related to aging in silence. This dynamic can also create a disparity in natural supports for these individuals and an increased hardship to aging-in-place (Cook-Daniels, 2011). The choice to grow old within a community or with loved ones close-by is often an option that is dangerous or unavailable to aging LGBT community members (Gabrielson, 2011). As the number of aging LGBT persons grows, so too does the need for culturally competent health care that addresses the unique health needs of this population (Landers, et al., 2010).

Characterizing life quality throughout the life span as “personal pleasure and satisfaction, good mental health, meaningful relationships, valued social roles, feeling secure, and the freedom to do things without restriction” (Huges, 2009, 663). A common fear many older adults face is the quality of their future physical health, which may include admission to a nursing home or a skilled nursing facility as institutionalization is a shared fear of many aging persons should they become unable to care for themselves (Stein, Beckerman & Sherman 2010). LGBT elders must cope with the additional apprehension about living in a setting that does not account

for sexual orientation, or where discrimination occurs because of sexual orientation (Landers et al., 2010). Many older lesbians and gay men feel compelled to subvert their sexuality or their close, personal relationships in order to receive quality, competent health care (Haber, 2009). While many of the needs and concerns of LGBT older adults are similar to those of their heterosexual peers, older lesbians and gay men must also confront a unique variety of internal and external barriers to accessing needed services and receiving quality care (Anetzberger, et al., 2004). These types of concerns are often reported among older lesbians and gay men, although gay men tend to highlight a fear of loneliness in older age, a reduced social life, and marginalization from the gay community and lesbians emphasize concerns about lack of financial resources and appropriate care and living arrangements (Huges, 2009).

An important consideration in providing comprehensive, culturally competent healthcare to the LGBT community is that each letter in LGBT, though frequently lumped together for convenience, is a universe of distinctive histories and experiences. With the strict social construction of gender where traditional roles were deeply reinforced through religious beliefs, work environment and leisure activities such as sports and social gatherings, many older men experienced sex role assignments tilted towards being doctors, politicians, fathers and husbands as the expression of masculinity (Duggan, 1990). Older gay men grew up in a world of sexual conquest, where masculinity and machismo were the preferred posture, and a good man married and started a family (Duggan, 1990). Societal homophobia and heterosexism viewed feminine or gay men as sick, sinful or criminal (Morrow, 2001). Declared as feminine, soft or sissy, many feminine activities such as art, cooking, and dance were exclusive arenas for heterosexual women (Andermann, 2010).

Society encoded girls and women to produce a household, to limit them to a family unit and to repress sexuality or limit sexual activity for reproductive purposes only (Duggan, 1990). Older adult women who identify with the L of LGBT, lesbians, were taught that homemaking and motherhood was the epitome of a good life (Gabrielson, 2011). The fairer sex were expected to the peace, maintain a good home, raise strong boys, and be available for-and waited on-their husbands (Ford, 2012). For women of this era, interest in athletic endeavors, science, politics and higher education received frowns, harsh words and sometimes violence and sexual assault (Meriam, 2012).

According to Kamano (1990), the social construction of gender categories refers to the rigidity and clarity of the definition of what are men's roles and what are women's roles, which meant gay men and lesbians had to learn to conceal their sexual identity as a means of survival. To avoid violence, harm or harassment, older lesbians and gay men had to lead hidden, clandestine lives because of their sexual orientation (Morrow, 2001). Much of the traditional social construction for gender is still strong today, but was deeply rooted and encoded for the elder LGBT community, who had a significantly restricted social definition of gender norms during their youth in the 1930's, 40's and 50's (Morrow, 2001). According to Duggan (1990), many scholars today view sexuality not as a biological or instinctual drive, but as a socially constructed aspect of human relations, which is central to the organization, and function of society. Unfortunately, prevailing gender norms, institutionalized medicine and Judeo-Christian religious beliefs, pillars of a functioning society, have a history of marginalizing, excluding or dehumanizing members of the LGBT community (Morrow, 2011).

As part of the evolution of attitudes towards homosexuality, there is an emergence of professional services and programs designed for LGBT people. Many of the service providers

who responded to the Fenge and Hicks (2001) survey asking to rate their agency's quality in caring for all elders overwhelmingly (60.9%) felt the services provided by their particular elder service agency were appropriate. Yet, elder members of the LGBT community feel differently. Most LGBT elders feel uncomfortable disclosing their sexual orientation (Cook-Daniels, 2011). The Gay and Grey project (Anetzberger, et al., 2004) in England, found that only 14% of LGBT elders felt comfortable with revealing their sexuality while visiting a healthcare provider, despite feeling it was an important component. The primary reason given for feeling uncomfortable was the fear of receiving different treatment; elders desired a safe atmosphere inclusive of diversity (Fenge & Hicks, 2011). Rejection or neglect by healthcare providers or other residents in long-term care facilities is another prominent concern of LGBT elders. Some LGBT older adults fear having to go back into the closet for personal safety if placed in a mainstream long-term care facility (Stein, Beckerman & Sherman 2010).

This constant dilemma of who and when to tell, or when to come out, coupled with the anxiety caused by this dilemma leave LGBT elders more susceptible to health risks (Morrow, 2001). LGBT elders are more vulnerable to isolation, low psychological fitness, depression and low morale later in life (Stein, Beckerman & Sherman 2010). LGBT elders have specific needs based on their previous life experience that could be detrimental to long-term health and well-being and quality of life if these unique needs are not addressed (Concannon, 2009). The comprehensive study of lesbian and gay elders conducted by Stein, Beckerman and Sherman (2010) echoed some of the psychological concerns LGBT elders voiced in the Fenge and Hicks (2011) study. These findings indicate that detailed educational programs for staff in long-term care facilities should sensitize providers to the issues faced by gay and lesbian elders. A supportive staff could ease the process of adjustment to care and allow residents to feel safer and

more comfortable as they live out their years in a positive, compassionate environment (Stein, Beckerman & Sherman 2010).

The fact that most health professionals and social workers automatically assume that their patients or service users are heterosexual is an assumption that perpetuates the marginalization of older lesbians and gay men (Concannon, 2009).

### **Methodology**

In order to gain a more comprehensive understanding about the daily and long-term challenges that confront aging members of the LGBT community and to discern which obstacles related to aging successfully impact LGBT elders, this research was guided by the central question “What are the unique challenges confronting members of the LGBT community as they age?” In addition to universal aging issues, members of the LGBT community experience a variety of complications that influence their physical, emotional and psychological health. I wanted to explore these issues of aging more fully, informed by the lives of LGBT elders and the care providers charged with tending for this specific group. To accomplish this goal, it seemed most appropriate to interview self-identified members of the LGBT community who were aged sixty or older, and to interview individuals in the health care field who have direct contact with, providing services for older adults.

#### LGBT Elders

Recruitment strategies focused on support groups that used LGBT as an umbrella to advocate for members. Flyers placed at community-based Counsel of Aging locations aided in the recruitment of elder members belonging to the LGBT community, with the intent of geographical variety; these locations included Provincetown, Yarmouth, Brookline, Boston and

Hyannis, Massachusetts. An internet search for organizations supporting or promoting healthy aging for the LGBT community revealed several contact organizations. These organizations included Fenway Health and the LGBT Aging Symposium, the LGBT Aging Project of Boston and the Stonewall Communities of Sharon and Boston. These organizations received contact via phone calls and e-mails, which included information on the research project, including a recruitment flyer. I also attended several monthly events organized loosely under the Stonewall Communities organization that promotes LGBT rights and awareness. These events included the Lakeside Café for LGBT Seniors, Friends and Allies, the Back Bay Café Emmanuel, and the lecture “Stonewall: Forty Years In.” No transgendered people participated in an interview for this study, nor were transgendered-specific organizations targeted as a source of potential participants. From these various recruitment strategies, lesbian, gay, bisexual or transgendered individuals were exposed to the recruiting process and were welcomed to participate in the study.

Participants consisted of seven gay men, one bisexual man, and four lesbians. The eight men interviewed for this project were between 72 and 84 years old while the lesbians were 62 to 69 years old. Two male couples, constituting four of the participants, were interviewed together. Both couples were married in the Commonwealth of Massachusetts. Another individual participant, while not legally married, was in a committed, long-term relationship. His partner was willing to participate in the research but scheduling conflicts prevented his participation. Three of the women were in committed, long-term relationships, while the fourth was a single woman. Interviewing alone was the third female, who is also in a committed relationship, as her partner did not participate in the research. The one bisexual male interviewed was a single man.

Interviews were approximately one to two hours long and occurred either in the homes of the participants, at local senior centers, or in public areas of the participants’ choosing in Boston,

Rhode Island or on Cape Cod. This study used a series of open-ended questions designed to uncover themes, patterns and concerns important to the LGBT elders. All questions were reviewed with participants prior to the interview. Questions included general information about the participant, if and how they identify as a member of the LGBT community and how comfortable they are about revealing their sexual identity. Follow up questions were utilized for clarification or for greater depth. Other questions pertained to general health issues and concerns encountered during interactions accessing health care such as:

- As a member of the LGBT community, what has been your experience in trying secure elder services?
- What are some of your concerns or fear regarding elder services and quality of care?
- As an elder, have you experienced discrimination from medical or service providers based on your sexual/gender identity?
- What has been your experience of service providers acknowledging or addressing your sexual/gender identity?
- As an elder, have you experienced discrimination from medical or service providers based on your sexual/gender identity?
- What has been your experience of service providers acknowledging or addressing your sexual/gender identity?
- How supported or connected do you feel as an LGBT elder? These supports can be family and friends, community members, or service/medical providers.
- How comfortable do you feel in revealing your sexual identity to medical or service providers?

## Service Providers

Initiating the recruitment of service providers occurred through the main office of Elder Services of Cape Cod and the Islands (ESCCI) and subsequent snowball sampling aided in the recruitment of participants. A presentation of the scope and intent of the research project, given to the social workers in the Home Care department of ESCCI, produced one volunteer willing to consent to a recorded interview and the name of another service provider who worked closely with older adults. The intent of this project was not to interview providers that worked specifically with LGBT older adults. Instead, the intention was to interview providers who worked with older adults in general and to develop a deeper understanding of the specific training, if any, provided caregivers about the unique needs and concerns of LGBT older adults.

The two service providers interviewed were from Elder Services of Cape Cod and the Islands (ESCCI) or from a subsequent outreach program located on Cape Cod, contacted through ESCCI. While many service providers declined to participate in the interview process, several health care professionals answered a few unofficial questions during the recruitment phase of the research, either during telephone contact or via discussions about the nature of the project. Through these interactions with the service providers, some information pertinent to the research was obtained.

Both research participants were female, had been in the field for a minimum of twelve years and had been working with older adults for most of that time. Both interviews took place at the residence of the service provider and lasted between one and two hours. Questions were designed to clarify the current position occupied by the service provider, their level of educational or professional training in caring for elders and if there were ongoing training

opportunities available to them about elder services. If there were ongoing trainings offered, how often they were able to attend trainings and what type of training did they receive? Other questions addressing elder concerns and healthcare, with a specific emphasis on LGBT older adults included:

- What is your educational or professional training in caring for LGBT elders?
- How comfortable do you feel in working with LGBT elders?
- Are there ongoing training opportunities available to you about LGBT elders? If so, how often are you able to attend trainings? If you have been to trainings about LGBT elders, what type of training did you receive?
- How many elders in your population or client load do you think are LGBT? How many LGBT elders do you estimate you may have worked with over the course of your career?
- Do you think there are aging issues specific to LGBT elders? If so, what might they be?
- What other training would you like to see in an effort to assist this population?

The question selection was designed to highlight the discrepancy between general elder care and culturally specific care for LGBT elders. Interviews conducted with both service providers and LGBT elders were recorded. After recording all interviews, the data were transcribed using the naturalized transcription style. Naturalized transcription style describes the conversation while recording all involuntary, subconscious sounds uttered by the participant (Chenail, 2011). Due to the intense, personal nature of the subject matter and questioning, naturalized transcription illustrated the hesitancy, caution and reluctance some participants may have felt during these interviews. Incorporating the cadence as well as the content was

imperative. The data gathered through the interviews were coded using grounded theory, which aims to generate or discover a theory based on information obtained from the interviews. Coding is a way to make sense of the data by identifying themes, keywords and phrases. Grounded theory aids in developing categories of themes, identifying how participants define their own situations, understand the problems that confront them and pinpointing common life experiences (Denzin and Lincoln, 2011).

## **Findings**

### LGBT Elders

Throughout this study, participants expressed many concerns about aging; including several common themes unique to the LGBT population emerged. The bulk of the literature (see Fenge & Hicks 2011; Huges, 2009; Stein, Beckerman & Sherman 2010; and Tax, 2012), indicates that elders are principally concerned with quality health care and culturally competent medical professionals. However, social support networks, broader social change and equitable legal rights emerged as stronger themes over the course of this study. Eight out of twelve participants stated that their primary concerns were social support networks and broader social change. As Alfred<sup>1</sup> noted: “My [partner] has excellent benefits, but I can’t get insurance coverage [on his] work policy.” This focus on social supports and broader social change stands as one of the most significant findings of this research as it relates to the areas of greatest concern for LGBT elders.

### Quality Health Care

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<sup>1</sup> All participants have been assigned a code name. All identifying information has been removed

When asked: “How supported do you feel in revealing your sexual identity to medical or services providers?”, two of the respondents indicated that culturally competent medical environments that are accepting and well versed at addressing the specific needs of LGBT elders was a primary concern. All participants identified medical competence and skill as their foremost interest in selecting medical professionals for aging concerns related to physical health. Nine out of twelve respondents stated that their sexual identity did not play a factor in choosing medical professionals. As Frank commented, “I don’t feel it matters who I sleep with for the doctor to know if I have high blood pressure, and besides, I never felt it was important [to inform the doctor of] my sexuality.” Psychological wellbeing elicited a different response. When asked “How comfortable do you feel in revealing your sexual identity to providers?” eight out of twelve respondents indicated they would be uncomfortable unless they knew the caregiver had previous experience working with the LGBT population. As Suzanne stated, “If I went to see a counselor, I would want to work with a lesbian, she would have insight into what I’m experiencing.”

### Couples and Individuals

Individuals not in partnered relationships expressed concern about maintaining connections and supports within the direct community. Social isolation is a common concern with older adults as difficulty obtaining secure transportation, inadequate opportunity for social engagement and financial constraints affect many elders. LGBT elders experience more barriers in maintaining community connections and are less likely than heterosexuals to access mainstream senior centers or aging services (Cook-Daniels, 2011) One participant, Rodger, who is single, articulated it as no longer wanting to “go it alone”, whether it was going to dinner, to

the movies or just for a social gathering. Rodger expressed a desire to share in standard social behavioral norms and experience basic camaraderie with his fellow seniors.

All of the couples interviewed in this study were concerned with legal rights and partner accessibility. Couples wanted social change and supports that help foster a society in which members of the LGBT community enjoy uniform application of constitutional rights of equality, respect of privacy and personal autonomy. LGBT elders who have learned to cope with harassment and discrimination during their life now desire changes in federal, state and local policy to include LGBT-specific legislation addressing legal rights.

### Social Support Networks

Prior research (Anetzberger, et al., 2004, Fenge & Hicks, 2011, Haber, 2009) suggest that gay men in particular will isolate more wholly than lesbians, choosing to live alone, yet the trend seen in this particular study demonstrated a substantially different pattern. Participants passionately joined and participated in numerous gay-friendly groups, clubs and gatherings. When asked a follow-up question on how identifying as an open member of the LGBT community provides access to neighborhood-based networks, Edwin noted, "There are some places to go, I just wish there were more." All participants expanded or commented on the issue of not having enough social support networks within the community, or not having either enough diversity or enough exclusivity within a specific group. As Rosie stated, "Sometimes I want to be with my gay friends, and sometimes I just want to be with people." Whereas many participants experienced a high comfort level with attending LGBT-focused groups, one participant stated that he wanted to experience social inclusion as an individual, saying, "If I want to go play cards, I don't always want to follow the rainbow." The bisexual male interviewed expressed a desire to

attend a bisexual meeting or event, instead of strictly one for “-gay men, because I’m not gay, I like women too.” His answers illustrate the diversity within the LGBT community and the difficulty in providing comprehensive programs to meet the assorted needs of a population that is often lumped together as one, singular entity.

In this study, age, relationship status, and gender influenced the absence or presence of social supports. This study indicated that the isolation of gay male older adults developed along the age continuum more frequently than sexual identity. “I would like to go out, but most places cater to the younger crowd, and I am not interested in partying all night,” said Roderick, a single, gay man. Relationship status was a significant determining factor in the level of community supports and social activities. Single men and couples participated differently, with couples being more deeply involved in community activities. As such, participants in long-term relationships interviewed for this project encountered fewer issues with isolation. Julio said, “If I don’t feel like going anywhere, or getting up, Ben often encourages me. We take turns motivating each other.” One couple provided an integrative way for aging members of the LGBT community to access local elder supports, such as Counsel on Aging facilities. Alfred introduced a “Cabaret Night” designed to connect heterosexual and same-sex elders in an atmosphere of fun and reminiscence with music and stage productions from their youth. A fundraiser for local politicians who support general elder concerns helped individuals feel connected to the community at large, as Cheryl said’ “If it helps the entire community, that should help me also, right?”

This study also revealed how gender difference played a role in community involvement. Male participants in this study had spent a significant portion of their lives mirroring heterosexual behavior, to the point of getting married, having children and raising a family. It

was only after embracing their sexual identity and becoming involved in a same-sex relationship did they actively seek out community supports within or outside of the LGBT community.

Alfred stated that it was not until he and his husband were married and purchased a home that he began to take an interest in the community in which he resided. He reflected: “It was here, in town, after we bought this rundown piece of property, that we began to take an active interest in where we lived. In what the local politics provided for us.”

Women in this study had built more support networks throughout their lives, including, but not limited to their membership in the LGBT community. As Rosie stated, “I have always been passionate about joining groups, even before I came out. I just felt more connected when I was involved, and when I came out, I came out hard”. The four women in the study discussed being more open about their sexuality to service providers; less fixated on youth, beauty and sexual attractiveness; willingness to become involved with LGBT groups; and took a stronger spiritual posture than the men take in this study.

Another significant finding for the study was youth outreach, which was also a primary concern to LGBT elders. Many participants in this study experienced discrimination, violence and isolation growing up and feel compelled to impart their knowledge to the younger generation. As Donnie stated, “We grew up in an era that was not acceptable, we had to meet over there, hidden. We had to play the game, get married, or join the military. So we say to the young kids, ‘get involved, and stay active’”.

#### Social Change and Legal Rights.

In this study, as previously mentioned, participants in partnered relationships focused more on social change and legal rights such as access to a hospitalized partner and future

financial concerns such as pension or inheritance than did their single counterparts. Paperwork, such as marriage license, health care proxy or durable power of attorney was also a major concern. As Frank said, “The decision making is very important, and until they do something at a federal level, we are not safe.” Four out of five partnered men interviewed echoed similar sentiments. These concerns did not seem to be as significant for participants who were not in a partnered relationship, as reflected by Peter’s comment about: “wanting to live where I can meet people like me and enjoy the rest of my life.”

Six of eight participants in committed relationships discussed the freedom to travel as a couple. This included the freedom to travel as a couple without documentation such as power of attorney, health care proxy, or a marriage license. This also included personal comfort and security when traveling outside of the New England region; a chief concern of the participants in a committed relationship or marriage was the recognition of their union when they were traveling outside of the state, which honors marriage equality.

Common with all aging couples is the concern of what will happen to the surviving member of the relationship. LGBT couples that are aging together have the added burden of not having their relationship recognized legally. This discrepancy creates anxiety over the safety and security of the surviving partner and creates concerns to how much access is available in the event of a disability or health emergency. One couple commented on the “enormous amount of paperwork” that they carry when they travel outside of the State of Massachusetts. This paperwork includes power of attorney, healthcare proxy and their marriage certificate from Massachusetts. These documents are used for protection or identification purposes to gain access to their partner in the event of an accident or hospitalization.

Federal recognition is a primary concern of married, aging members of the LGBT community. This recognition will allow committed couples to age securely and with dignity. Edwin reflected: “What will happen to Alfred when I’m gone, everything is in my name? Will he have to fight a family member for what I gave him?” Three out of four of the partnered women interviewed discussed equality in broader terms. As Sally indicated: “We have to support not just our own community, or the lesbian community, but the larger community that we interact with, and live in, for the betterment of everyone.” Social change was expressed as rights and acceptance at a local, community-based level, a state level and on a federal level. The ability to own property as an accepted member of the community, organize and advocate for changes to programs that are accessed by older adults and participate in municipal decision-making were equally valued. As Rosie stated, “I really enjoy living here, and it would be nice to get something going in town. Like a meeting place, with music, that everyone could enjoy.”

### Service Providers

As previously stated, and despite multiple attempts at recruitment, only two service providers agreed to be interviewed for this project. The two providers interviewed indicated a lack of LGBT specific training in their programs. New England provides many different opportunities for education related to the specific needs of LGBT older adults; any information gained by the two participants was not officially incorporated within their organization’s framework, but acquired independently. In other words, respondents felt that any information pertaining to LGBT older adults learned outside of their agency of employment was for personal reference only. Providers indicated a shortage of resources, an understaffed workforce and the absence of specific training in the unique needs of LGBT older adults.

Joan commented that her agency has required client medication checklist does not include AIDS related medications. She stated, “Typical aging medication such as Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) or heart medication, such as digoxin, on our reports, but there was never a question or comment on anti-AIDS medications.” This is one example of a lack of a comprehensive understanding to the possible needs or difficulties facing aging members of the LGBT community. Without taking into consideration the unique medical needs members of the LGBT community may experience, health care providers foster the division between quality healthcare and subpar healthcare, creating an uneven distribution of care. This lack of awareness and concern reinforces marginalization and isolation in LGBT seniors.

Betty said, “For caseworkers in this agency, even those who identify as members of the LGBT community, the need for specialized services for members of the LGBT population that are aging is just not seen as a high priority.” The two service providers expressed being overwhelmed, due to the sheer numbers of older adults involved with their agencies. Some caseworkers see over 100 elders a month, making it difficult for the workers to provide differentiated care, let alone receive training on the specific experiences and needs of their LGBT cliental. The two respondents both suggested that providing any service is better than not providing services, even if that means providing a brand of homogenized care.

### **Discussion**

In qualitative research, the design emerges as the study unfolds and we interpret phenomena in terms of the meanings people bring to them. In this particular sample of interviewees, the trends indicate that social change, support networks and community

connections were of primary concern, but an accurate, historical account was also necessary. Many participants indicated the need for culturally competent healthcare, acceptance and opportunity on both a local and national level. While every member from the LGBT community interviewed for this project experienced discrimination, isolation or violence, many were more concerned with the future of the younger generation of LGBT members and their ability to live their life free from the prejudices of the past. Because of its small sample size, volunteer nature of participants and limited geographical focus, the conclusions of this study are not necessarily generalizable to other areas. Still, the voices of the twelve elders and two service providers in this study shed light on significant issues faced by aging members of the LGBT community. These include broad social supports, stronger legal rights and competent health care.

#### Legal Rights: Beyond the Medical Checkup

One of the most significant findings from this study is that the desire to feel safe and accepted by health care providers was important, but it was not the dominant concern. Aging in a country that disregards non-normative gender expression or minimizes sexual identity creates hardship beyond the potential comfort of an hour-long medical checkup. Aging adults in the LGBT community who participated in this study still distrust the medical establishment that has failed them in the past. Participants that felt guarded about expressing their sexual orientation to medical professionals or unclear how the knowledge would fit in their care plan, did want a compassionate, welcoming environment when receiving healthcare services. As with any aging member of our population, LGBT elders deserve to age with dignity and respect in an environment that is safe, affordable and culturally sensitive, simultaneously treating the health of the entire individual.

### Federal Programs and Policy Initiatives

Increasing family-related legal protections will improve the quality of life for LGBT older adults. Not surprisingly, current discussions centering on Social Security reform, changes to Medicare and Medicaid and the continued development of aging services or healthcare provisions have major implications for the older adult population (Tax, 2012).

Many proposed benefits gained by the aging population are usually denied to same-sex couples based solely on assumed, heterosexual identity (Apuzzo, 2001). As one example, the Older Americans Act (OAA) does not acknowledge the lives and needs of LGBT elders, despite ample evidence of heightened vulnerability or the need for unique aging supports. As the bill stands today, its legal definition of “family” does not include LGBT relationships (Apuzzo, 2001). The Older Americans Act, first enacted in 1965, federally funds programs that support millions of elders throughout the United States. These programs include home and community-based services such as meal-on-wheels food delivery, adult day care services, transportation, information and referral, advocacy assistance, and social, legal, and employment services (Apuzzo, 2001). Programs that can identify remove or lessen barriers that aggravate economic insecurity, social isolation, and various health challenges related to aging will remain underfunded if financing for these programs is not provided and protected. Including issues and concerns relevant to the aging LGBT community in the Older Americans Act (OAA) and similar legislation would be strong first step towards meeting the specific needs of this vulnerable population.

Participants were forthcoming in stating that they feel denied basic human rights because they lack sufficiently comprehensive legal rights. For those participants in a long-term

relationship, this lack of legal status has significant implications, as the legitimacy of their relationship was limited. Signed into law in 1996, Defense of Marriage Act (D.O.M.A.) subsequently denies same-sex couples over 1,100 of the federal benefits given to married couples; a challenge to this law brought by a LGBT elder and is currently being heard in the Supreme Court in two separate cases on DOMA. The decision on these two cases, scheduled for June 2013 has profound and lasting implications related to the health and welfare of older LGBT couples. By upholding or striking down components of the law, the Supreme Court could potentially validate same-sex relationships or relegate LGBT elders to a life more securely closeted. Current policy restricts gays and lesbians from marriage, one of the most important relationships in life, stigmatizing a class of citizens based upon their status and labeling their most cherished relationships as second-rate, different, and unequal. By overturning DOMA, the same-sex couples who are denied benefits, benefits such as being able to file joint tax returns or receive Social Security survivor benefits, will have access to more of the resources that heterosexual couples enjoy; some changes would particularly benefit affluent LGBT couples in securing, and financing, quality healthcare. Without the higher rates of taxation on health benefits that non-married dependents pay, same-sex couples would better afford health coverage.

#### Inclusion of LGBT-specific Data

One recommendation drawing from study findings relates to the inclusion of LGBT-specific data. The inclusion of data specific to LGBT elders would ensure policy design based on specific needs. Collected data can generate remarkable, information-driven insights into the devastating health disparities facing LGBT seniors (Cook-Daniels, 2001). These disparities include access to health care, HIV/AIDS, mental health concerns, and a higher incidence of chronic physical conditions. LGBT elders are more likely to delay getting the necessary care and

prescriptions, and more likely to resort to visiting emergency rooms for care, driving up the overall cost of healthcare. LGBT adults are more likely to experience psychological distress, are more likely to need medication for emotional health issues, and are more likely to consume alcohol and use tobacco. By understanding the unique health needs and specific difficulties facing LGBT older adults, data on sexual orientation and gender can support effective outreach policies and identify opportunities that serve the LGBT community more fully.

### Advocacy

In order to fully respond to the needs of LGBT elders, advocates and policymakers could consider several avenues. Advocates would be wise to insist that new and existing federal and state studies on physical and mental health include information on LGBT people and, that health care workers become trained regarding the unique disparities. Policymakers should enact health plans that cover the needs of LGBT older adults. Providing more resources and culturally competent centers, advocates can assist LGBT seniors to maintain independence, increase social contact and form interdependent communities intent on benefitting every member.

### **Conclusion**

Stemming from my research experiences, I would also assert that advocacy for and with LGBT elders and policy changes need to be actualized and implemented. It is no longer enough to research and study and compile evidence. It is time to make significant, long-term changes to how we treat all of the aging members of our population. At a lunch in the greater Boston area for LGBT elders, several participants and leaders in the community indicated that they felt overwhelmed by the numerous requests for interviews and survey studies. Many elders felt discussing their unique situation was beneficial and would provide useful information, but did

not see their insights implemented to create change or enhance their wellbeing. Poverty, housing, food and fair treatment are still elusive. Gathering information and learning from a disenfranchised group is useless without converting the raw data into policy, laws and regulations that advance the targeted minority group. Only empowered advocates implementing gathered information will change a government that finds it legal to deny a person a job or the right to adopt foster children based solely on actual or perceived sexual orientation. Otherwise, the information will remain useless without a commitment to overcoming social inequity, fostering hope for a future where no person, regardless of his or her relationship status or gender identity, has to suffer the injustice of discrimination or forced minority status. Each person's life experience is very different, as are his or her encounters with gay acceptance and their interactions with healthcare professionals. Many gay individuals want their sexuality taken into consideration and want treatment to consist of respect, dignity and equality. Education and awareness training for all staff involved in the care of older people should address homophobic prejudice. The anti-discriminatory policies that embrace diversity and equality need to be enshrined in the codes of conduct for all professionals involved in the care of older adults.

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