Competent, affirming practice with older lesbian and gay adults

With the number of lesbian and gay (LG) older adults expected to swell to nearly 7 million in the next decade, psychologists will increasingly be working with these clients. This article provides an overview of the concerns these clients face related to stigma and discrimination, health disparities, legal issues and barriers to long-term care, among other issues.

By Jennifer Hillman, PhD, and Gregory A. Hinrichsen, PhD
The number of people facing such discrimination is quite large: Approximately 3 million older adults in the United States identify themselves as lesbian or gay, and that number is expected to swell to more than 7 million by 2025. And research shows these clients are not getting the care they need. The APA Task Force on Bias in Psychotherapy with Lesbians and Gay Men, for example, found that older LG clients may even be inadvertently mistreated by providers due to a lack of knowledge about this population and heterocentrism — the negative attitudes and behaviors associated with any deviation from heterosexuality. Compounding these challenges is that older LG adults are one of the least empirically studied populations in terms of their mental health needs and adaption of psychotherapy to best address those needs.

Historical and cohort effects
Among the most important concepts to consider when working with LG clients over age 50 is that all of them lived through a time when their sexual orientation was labeled immoral, illegal and pathological. Homosexuality was only officially removed from the Diagnostic and Statistical Manual in 1973. Gay and lesbian people who revealed their sexual orientation in their younger years often suffered significant psychological and physical abuse from the larger community, including verbal harassment and social isolation, as well as sexual and physical assaults. These experiences may present themselves in later life as diffuse anxiety, depression, somatic distress or even post-traumatic stress disorder.

APA Guidelines for Psychological Practice with Older Adults encourage psychologists to take into account the impact of being part of a generational age cohort (e.g., baby boomers) because experience and attitudes vary among age cohorts, including attitudes toward mental health services. LG baby boomers experienced significantly different historical events than did earlier age cohorts. For example, the oldest LG elders came of age in the 1950s when President Eisenhower’s 1953 Executive Order #10450 called for homosexuals to be fired from government jobs. Few LG individuals openly discussed their status for fear of discrimination and violence since people who were found to be engaging in same-sex behavior could be and were sent to prison or mental hospitals. No federal or state laws protected LG individuals from victimization. The mental health establishment offered “treatments” to change homosexual orientation through certain psychotherapies, electroconvulsive therapy and hormones.

Previous generations of LG persons clearly experienced enormous social pressure to suppress sexual expression or hide sexual orientation. As a result, earlier generations of LG elders — the now oldest-old LG elders — are more likely to have married opposite-sex partners, and in late life have ex-spouses, adult children and grandchildren when compared with LG baby boomers. Compared with their oldest-old heterosexual

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This incident happened just three years ago, despite significant strides in gay rights in the United States. Fear of stigma and outright discrimination in a variety of health-care, institutional and social service settings continue to be documented among aging lesbian and gay (LG) adults, even among those who live in more socially progressive urban areas.

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peers, however, these oldest LG elders have fewer biological relatives available to assist them with instrumental and financial needs related to long-term health care.

In contrast, baby boomers came of age during the gay rights movement catalyzed by the 1969 Stonewall riot in New York City. These baby boomers grew up with the American Psychiatric Association’s (1973) policy statement that homosexuality was no longer regarded as a mental disorder and the repeal of many states’ laws that criminalized homosexual behavior. Due in part to these events, LG baby boomers may represent the first LG age cohort to be more inclined to seek mental health care. Future cohorts of LG elders (e.g., the millennials) will likely have different experiences compared with current generations of LG older adults, since they came of age when states began to recognize same-sex marriages. In summary, although every individual’s experience of stigma and discrimination in relation to minority sexual orientation is unique, cohort effects remain influential.

**Diversity among lesbian and gay elders**

Aging LG adults who are members of ethnic and cultural minority groups, conservative religious affiliations or rural communities often face additional social stressors. For example, a 74-year-old black lesbian in Chicago may experience ageism, heterocentrism, sexism and racism, whereas a 62-year-old gay Latino man in rural Pennsylvania may face significant social isolation as well as ageism, heterocentrism and racism. Cultural or ethnic-minority LG elders may face additional forms of heterocentric discrimination within their own ethnic, cultural and religious communities. In contrast, some LG minority elders may be assigned positive qualities; Native American “two spirit” elders were traditionally revered and granted special social status.

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Most research on LG adults has been collected from white, highly educated gay men living in urban areas. Very little is known about older LG minority elders, particularly in rural areas, who are black or Hispanic or the oldest-old. Similarly, practitioners should never make global assumptions about any client from any minority group. The influence of ageism, heterosexism and racism (among other stigmatizing factors) upon aging sexual minority group members is likely to be cumulative and perhaps exponential beyond the negative impact of each individual type of discrimination. A study of older gay black men reported significantly higher levels of perceived ageism than older gay white men, significantly higher levels of racism than younger gay black men, and significantly higher levels of homonegativity (overt negativity and hostility in relation to their gay sexual orientation) than both younger black and white gay men (David & Knight, 2008). Unfortunately, stigma, discrimination and social isolation may substantially contribute to health disparities, barriers in long-term care and legal inequalities evident among LG people.

**Physical, mental and sexual health disparities**

According to the Centers for Disease Control and Prevention (2011), LG adults experience significant physical and mental health disparities compared with their heterosexual peers. Awareness of such discrepancies is vital when working with older LG clients. Concealing one’s sexual identity from healthcare providers can lead to ineffective or deleterious health care. Various reports indicate that more than 40 percent of LG adults age 50 and older suffer from at least one disability or chronic illness, and are more likely to smoke and engage in binge drinking than their heterosexual peers.

LG elders are also more likely to delay seeking treatment for physical health problems, and to experience increased risk of elder abuse and neglect. LG elders are two times more likely to live alone and four times less likely to have adult children to call upon for help and support. In fact, one in five older LG adults reported having no one to call on in a time of crisis, compared with only one in 50 older heterosexual adults (Brookdale Center on Aging, 1999).

Within the context of such limited social support, older U.S. LG adults appear to experience more mental distress than
their same-age, heterosexual peers. Nearly one in three older LG adults from a large-scale study of more than 2,300 LGBT U.S. older adults reported that they lacked companionship and felt lonely, and met criteria for clinical depression on a standardized measure. In addition, nearly one in three older LG study participants indicated that they seriously considered committing suicide at some point in their lives, often in response to concerns about their sexual orientation. A study of older LG Europeans revealed similar findings, in which internalized homonegativity and social stigma contributed to mental health issues.

In terms of sexual health, older women in general often encounter vaginal dryness and older men experience erectile dysfunction and prostate changes. Gay male elders face increased risk of infection for HIV and other STDs, and both older gay men and older lesbian women face challenges in terms of poor or limited preventative screenings and clinical care. Although gay men represent about 2 percent of the general population, they account for nearly half of all AIDS related deaths and new HIV infections. Specifically, more than 17 percent of new HIV/AIDS cases occur among adults over age 50, with older men having sex with men, and older black and Latino men, at greatest risk. In addition, within the last decade, new HIV diagnoses among adults over age 50 increased by more than 30 percent. Regrettably, no national HIV/AIDS education programs exist for older adults, much less an aging gay male population.

Older gay men in committed relationships also are more likely to face the diagnosis and treatment of prostate cancer than older heterosexual men. A committed gay man may have to face both his own and his partner’s diagnosis of prostate cancer. Like their heterosexual peers, older gay men often have limited and incorrect knowledge about prostate disease, and older black gay men possess the least accurate knowledge. Therapists can encourage older gay men to discuss their prostate health openly with both their medical providers and their own partners. Education about prostate health, as well as its treatment options, remains essential.

A primary concern for older lesbians is a failure to disclose information about their sexual orientation and history to their health-care providers. Despite prevalent myths held by both older lesbians and health-care providers that lesbians are immune to the transmission of STDs, nearly half of older lesbians report having heterosexual intercourse at some point in their lives, and 20 percent of all women who never had heterosexual intercourse are infected with the HPV virus, the primary cause of cervical cancer. Older lesbians should receive educational messages about their individual risk factors for STDs and screenings when appropriate. Therapists can encourage older LG individuals to discuss concerns about their sexual health, and help them communicate more effectively with their health-care providers, who are unlikely to discuss STDs with their older patients, regardless of their sexual orientation.

Caregiving and long-term care

A survey of more than 1,200 LG adults found that LG elders are twice as likely to serve as a caregiver for a parent, family member, partner, friend or neighbor, and spend significantly more hours per week providing that care, compared with their heterosexual counterparts. This finding supports the notion that older LG adults maintain a “family of choice” well beyond biological and legal boundaries. The psychological, physical and financial demands on this population should not be overlooked. Significant challenges also exist for LG adults in long-term care facilities. Discrimination, including outright hostility and substandard care, is well documented among LG residents in nursing homes and other institutional settings. Professional caregivers hold significantly more negative attitudes toward sexual activity among same-sex than heterosexual residents. Such negativity and hostility can even take the form of physical abuse.

Challenges to living authentically

Both fear of discrimination and fear of living an asexual lifestyle within a long-term care setting lead the majority of older LG adults to report that they want to live independently in their own homes, for as long as possible. To complicate matters, only 22 states have passed laws that prohibit discrimination based on sexual orientation in public or private housing. In other states, a nursing home or public housing administrator can simply refuse to admit an LG individual with no legal recourse available to that individual.

As a result, many LG residents in long-term care, including those who have lived authentically, feel compelled to “go back into the closet.” Some LG partners legally change their last name to match that of their partner’s, so they can live in the same room as “brothers or sisters.” Other LG residents decide to act straight, while others hide personal photos of partners and other mementos to avoid revealing their LG status. A therapist’s knowledge of these unique challenges and information about available resources is essential.

Legal issues and a call for advocacy

It is also vital for psychologists and their LG clients to become familiar with changing federal and individual states’ laws regarding same-sex marriage, civil unions and discrimination on the basis of sexual orientation so that they understand the benefits they are entitled to in care facilities as well as through government programs including Social Security and Medicare.

In 2013 the U.S. Supreme Court struck down Section 3 of the Defense of Marriage Act (DOMA; United States v. Windsor, 2013). That ruling granted same-sex married couples access to more than 1,000 federal rights, including 401(k) survivor and hardship withdrawal benefits, coverage under the Family and Medical Leave Act (FMLA), COBRA benefits, savings on federal inheritance taxes, veteran’s benefits and green cards for binational couples. The DOMA ruling also granted same-sex married partners access to federal Supplemental Security
Income, disability, death and spousal benefits. In addition, the federal provisions for Medicaid spend-downs—which are designed to keep a healthy spouse from losing his or her home and becoming bankrupt when paying for the nursing home care of an ill or disabled partner—also now apply to same-sex married couples. In 2015, the Supreme Court further ruled that individual states could no longer deny same-sex couples the right to become married.

Studies show, however, that lesbian and gay adults who live in states that fail to provide protection against hate crimes and employment discrimination based on sexual orientation were significantly more likely to be diagnosed with depression, dysthymia, generalized anxiety, and post-traumatic stress and alcohol abuse disorders than those living in states that did provide such legal protection. Allowing LG clients to express their anger and frustration in therapy about such legalized forms of discrimination is essential. The need for psychologists to advocate for public policies and state and federal laws that prohibit discrimination based upon sexual orientation is urgent and clear.

Adaptation and resilience

Although LG elders represent a unique, at-risk population, they also display evidence of significant adaptation and resilience. More than 80 percent of LG adults report that they engage in some type of wellness activity. A qualitative study of older LG adults suggests that many learn to cope with a stigmatized identity by developing a strong sense of independence, autonomy and inherent self-worth, as well as by establishing interests outside of their families and careers. Some researchers posit that successful coping in response to the stress of coming out may better prepare LG adults for life in an ageist society.

Social support is a critically important part of life that allows someone to adapt and adjust more easily to life changes and crises. One difference observed between LG and heterosexual elders is that LG elders typically garner more social support from friends and “family members by choice” than legal or biological family members. Although long-standing social norms suggest that family members are expected to provide instrumental support (such as financial help and caregiving), LG individuals have historically developed meaningful, supportive friendship networks, in part because their own families may be unsupportive of their sexual orientation. With a broader social network, LG elders are often better equipped to gather different types of support from multiple sources compared with their heterosexual peers.

Implications for practice, advocacy and research

Clinical settings can help LG elders feel more comfortable and accepted in a variety of ways. For example, therapists can change the language on intake and other forms to ask about one’s relationship versus marital status, and about family members by choice. They can also alter the physical environment in offices, waiting areas and websites by displaying or linking to magazines that reflect both LG and aging readership (such as Out More and AARP), or with pictures featuring LG couples and families from a variety of ages, racial, ethnic and cultural backgrounds. Therapists also can celebrate National Coming Out Day, World LGBT Pride Day and other LG-affirming events. For example, psychologists played a key role in U.S. Department of Veterans Affairs efforts to make VA health-care facilities more welcoming for LGBT veterans by working to develop more inclusive hospital visitation policies and establishing a policy on respectful care for transgender veterans.

To provide competent practice, psychologists themselves must examine their own attitudes toward both older and LG adults, particularly if coming from a culture or religious affiliation that does not affirm an LG orientation. Therapists also are advised to train staff and post a nondiscriminatory statement that equal care will be provided to all clients regardless of their age, sexual orientation, ethnicity, race, religion, physical ability and attributes, and gender identity. Simple exposure and familiarity with LG elders can reduce stigma and alert minority clients that options are available.
for competent, affirming care. Fostering the resilience of LG elders, including the nonfamilial exchange of care, participation in formal and informal LG and aging support groups, and increased health advocacy for HIV/AIDS, is highly desirable.

Consistent with the APA Practice Guidelines for older adults as well as those for LG adults, psychologists are encouraged to engage in advocacy for their clients as well as for LG elders at large to promote social justice and civil rights. Specifically, psychologists can advocate for changes in individual states to pass antidiscrimination laws that benefit older LG adults. Such laws would include protections against hate crimes and discrimination in private and public housing, including both nursing homes and assisted-living facilities. Of course, simply passing an antidiscrimination law does not prevent such discrimination; it only provides legal recourse for those affected.

To provide a safe and welcoming environment for LG elders in long-term care, same-sex couples should be able to share a room. To make this happen, staff training and even resident education are likely to be necessary. The VA training model and a staff training curriculum on LGBT elders developed by the National Resource Center on LGBT Aging are good resources.

Conclusion

Significant physical, sexual and mental health disparities exist among older LG adults when compared with their heterosexual peers. As more egalitarian same-sex laws are adopted by a variety of individual states in the United States, psychologists can play a critical role in advocacy for state and local legislation that prohibits discrimination based upon sexual orientation and will benefit the growing population of aging LG adults. Therapists also are encouraged to seek education and training on the unique challenges often faced by older LG adults, and to provide an LG-affirming practice to better serve this burgeoning, diverse population.

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