Later-Life Social Support and Service Provision in Diverse and Vulnerable Populations

Understanding Networks of Care

Edited by
Janet M. Wilmoth and
Merril D. Silverstein

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CHAPTER 7

LGBT OLDER ADULTS EMERGING FROM THE SHADOWS

Health Disparities, Risk & Resilience

Karen I. Fredriksen-Goldsen and Charles P. Hoy-Ellis

INTRODUCTION

Lesbian, gay, bisexual, and transgender (LGBT) older adults have largely been an invisible population, although they are now emerging from the shadows. Along with shifting demographics and profound graying of the global population, the older adult population is becoming increasingly diverse. Estimates indicate that more than 100 million Americans are aged 50 and older (U.S. Census Bureau 2013b). By 2030, it is estimated that nearly 133 million Americans will be aged 50 and older with the 50–64 age group shrinking slightly, and those 65 and older nearly doubling (U.S. Census Bureau 2013a).

Given population aging and the increasing diversity of the older adult population, the number of LGBT older adults is steadily increasing. Recent population-based data suggest that 2.4 percent of Americans aged 50 and older, which represents more than 2.7 million adults, self-identity as LGBT when adjusting for nonresponse and noncoverage rates (Fredriksen-Goldsen and Kim 2017). Due to the projection that the numbers of older adults in the United States will more than double by 2060, LGBT adults aged 50 and older will number more than 5 million within

the next few decades (Fredriksen-Goldsen and Kim 2017). When expanding beyond self-identification and taking into consideration intimate and romantic relationships and sexual behavior, the number of LGBT adults aged 50 and older is estimated to more than double. Despite the increasing number of LGBT older adults, they are rarely considered in health or aging research (Institute of Medicine 2011). Both the Institute of Medicine (2011) and the Centers for Disease Control and Prevention (CDC 2011) identify the lack of attention to sexual orientation and age as critical gaps in our understanding to reduce health disparities.

To date, most studies of LGBT aging have relied on those in midlife with limited attention to those over the age of 65. Yet, there are three cohorts of midlife and older adults living today (Novak 2013). Both age and cohort differences are important to consider among LGBT older adults, given the shifting social context as it relates to sexuality and the social and legal standing of LGBT people (see Table 7.1). LGBT older adults of both the Greatest and the Silent Generations came of age prior to the modern gay rights movement and during a time when same-sex behaviors, typically characterized as sodomy, were criminal acts in all 50 U.S. states (Carpenter 2012) and homosexuality was considered a sociopathic personality disorder by the American Psychiatric Association (Silverstein 2009). The Greatest Generation (b. 1901–24) came of age during the Great Depression and fought during World War II—a period wherein LGBT identities were largely absent from the public discourse. The Silent Generation (b. 1925–45) experienced the postwar boom and their coming of age occurred during the backdrop of the McCarthy era "lavender scare." With the widespread television broadcasts of the McCarthy trials, sexual and gender-minority identities not only entered into the popular public discourse but were cast as a threat to the very security of the nation (Canaday 2009; Johnson 2004).

Public discourse took a decidedly different turn during the period when the baby boomers (b. 1946–64) were coming of age and forming their sexual and gender identities. As a result of the Stonewall riots and other social movements of the time, LGBT people became visible to each other and to American society in an unprecedented way, marking the beginning of the modern gay rights movement. During this era, we also witnessed the beginning of the decriminalization of same-sex sexuality in 1962 and the removal of homosexuality as a sociopathic personality disorder from the revised second edition of the *Diagnostic and Statistical Manual*

Table 7.1: LGBT Midlife and Older Adults and Historic Events by Cohort

Historical Event	*Year of Event*	*Cohorts*		
		Greatest Generation (born 1901–24)	*Silent Generation (born 1925–45)*	*Baby Boom Generation (born 1946–64)*
		Cohort ages in years when experienced		
Emergence of medical discourse of "sexual inversion" as illness[1]	~1860s			
First known use of term "homosexual" in English language[2]	1892			
First of Greatest Generation cohort born (1901–24)	1901	0		
First of Silent Generation cohort born (1925–45)	1925	1–24	0	
Great Depression begins	1929	5–28	0–4	
World War II begins	1939	15–38	0–14	
World War II ends	1945	21–44	0–20	
First of Baby Boom Generation cohort born (1946–64)	1946	22–45	1–21	0
The Lavender Scare, a witch-hunt against homosexuals begins[3]	1950	26–49	5–25	0–4
Homosexuality designated as a mental illness in *DSM-I*[3]	1952	28–51	7–27	0–6
Mandated firing of federal and civilian homosexual employees[4]	1953	29–52	8–28	0–7
McCarthy hearings broadcast on television	1954	30–53	9–29	0–8
Illinois becomes first state to decriminalize sodomy[5]	1962	38–61	17–37	0–16
Civil Rights Act	1964	40–63	19–39	0–18
Stonewall riots[5]	1969	45–68	24–44	5–23
Homosexuality as a pathology removed from *DSM-II-R*[1]	1973	49–72	28–48	9–27
Gender identity differentiated from homosexuality in *DSM-III*[1]	1980	56–79	35–55	16–34
159 cases reported of what would come to be known as HIV/AIDS[6]	1981	57–80	36–56	17–35

(*continued*)

Table 7.1: Continued

Historical Event	*Year of Event*	*Cohorts*		
		Greatest Generation (born 1901–24)	*Silent Generation (born 1925–45)*	*Baby Boom Generation (born 1946–64)*
		Cohort ages in years when experienced		
Total U.S. AIDS cases reported: 733,374; died: 429,825[6]	1989	65–88	44–64	25–43
"Don't Ask, Don't Tell" military policy enacted[5]	1994	70–93	49–69	30–48
First protease inhibitors approved; HIV/AIDS soon becomes chronic[6]	1995	71–94	50–70	31–49
Defense of Marriage Act (DOMA) enacted[5]	1996	72–95	51–71	32–50
US Supreme Court rules sodomy laws unconstitutional[5]	2003	79–102	58–78	39–57
First baby boomers turn 65 years old "Don't Ask, Don't Tell" military policy ends[5]	2011	87–110	66–86	47–65
Supreme Court strikes down Section III of DOMA[7] Gender Identity Disorder becomes Gender Dysphoria in *DSM–5*[8]	2013	89–112	68–88	49–67
Supreme Court rules bans on same-sex marriage unconstitutional; full marriage equality state and federal[9]	2015	91–114	70–90	51–69

[1]Institute of Medicine 2011.
[2]Penhallurick 2010.
[3]Canaday 2009.
[4]Johnson 2004.
[5]Carpenter 2012.
[6]AVERT 2015.
[7]Liptak 2013.
[8]American Psychiatric Association 2013.
[9]*Obergefell v. Hodges* 2015.

of Mental Disorders (DSM-II-R) in 1973 (Silverstein 2009). The youngest of the Baby Boom generation also came of age during the early years of the AIDS pandemic in the United States, as LGBT communities organized to care for one another. According to findings from a Gallup poll (Gates and Newport 2012), approximately 1.9 percent of the surviving 30 million members of the Greatest and Silent Generations and 2.6 percent of the 76.5 million members of the Baby Boom generation identify as LGBT.

In order to investigate the complexity in the relationships between risk and protective factors and physical and mental health of LGBT older adults across age groups, we utilize the Health Equity Promotion Model (Fredriksen-Goldsen et al. 2014). The Health Equity Promotion Model recognizes disparities in health and highlights the need to promote the full health potential of LGBT older adults. This model illustrates how social positions and structural and societal risks, such as discrimination and victimization, intersect with adverse and health-promoting mechanisms to influence health outcomes in LGBT communities. The Health Equity Promotion Model expands upon earlier conceptualizations by taking into consideration how intersectionality of social positions, age group differences, and historical and cultural contexts over the life course influence both positive and negative health outcomes. LGBT older adults share some similar risk and protective factors with older adults in the general population, while they also experience unique strengths and challenges due to the marginalization of their sexual and gender identities. The Health Equity Promotion Model accounts for LGBT-specific factors that span individual, community, and societal levels, such as the disclosure of sexual and/or gender identity, internalized stigma, victimization, discrimination, diverse social networks, and social integration into the LGBT community, which have been documented to influence health and well-being in the LGBT population (Fredriksen-Goldsen et al. 2013a; 2013b). This model is a logical progression in LGBT health research; it provides an actionable framework that moves beyond documenting factors associated with LGBT health disparities by highlighting key leverage points for intervention and prevention efforts.

Based on a health equity perspective, in this chapter we draw from the extant literature and findings from *Caring and Aging with Pride* (Fredriksen-Goldsen et al. 2011; 2013a; 2013b; 2013c; 2014; 2015) to examine health disparities among LGBT older adults and explore how structural and environmental risks intersect with personal and social resources and

health behaviors. We also highlight the importance of understanding age group differences as they relate to the risks and opportunities experienced by LGBT older adults. In conclusion, the next steps for policy, services, and research are outlined to address the growing needs of LGBT older adults and their families. By examining the health and well-being and the risks and resilience of LGBT older adults, this chapter addresses the increasing heterogeneity in our growing, older adult population.

HEALTH DISPARITIES

Healthy People 2020 aims to reduce population health disparities and improve quality of life and, for the first time, LGBT people have been recognized as an at-risk population in national health initiatives. The critical need to expand health disparities research related to sexual orientation and gender identity has been identified in order to make informed decisions about health-related practices and policies (Institute of Medicine 2011; U.S. Department of Health and Human Services 2011). Health disparities are defined as preventable differences in population health that are attributable to environmental, economic, and social disadvantage associated with characteristics such as socioeconomic status, race/ethnicity, gender, sexual orientation, and gender identity (American Public Health Association 2008).

Most early LGBT-related health research focused on mental health outcomes (Fredriksen-Goldsen and Muraco 2010). This is understandable because LGBT people have a long history of being pathologized; it was only four decades ago that homosexuality was declassified by the American Psychiatric Association from being a "sociopathic personality disorder" (Silverstein 2009). Even today, gender variance continues to be stigmatized in the *DSM-5* (American Psychiatric Association 2013), with gender identity disorder reformulated as *gender dysphoria*, which is diagnosed as a psychological disorder only if its presence causes clinically significant distress.

Caring and Aging with Pride is the first federally funded project investigating LGBT aging, health, and well-being. In the first phase of the project, data from the 2003–10 Washington State Behavioral Risk Factor Surveillance System (WA-BRFSS) were analyzed (n = 96,992) to examine health disparities among lesbian, gay, and bisexual adults aged 50 and older. Next, to understand distinct risks and protective factors associated with LGBT older adult health, we distributed questionnaires via 11 community-based agencies' mailing lists from June

to November of 2010. To be eligible to participate in the study, potential respondents had to be 50 years of age or older and identify as LGBT. A demographically diverse sample of LGBT adults 50–95 years old, with a majority over the age of 60, was obtained (2,560 completed questionnaires that met study criteria were returned, with a response rate of 63 percent of mailed surveys).

The results of the study are yielding important insights into the lives of LGBT older adults and improving our understanding of the full range of health outcomes, as well as health disparities related to sexual orientation and gender identity. For example, lesbian, gay, and bisexual adults aged 50 and older, when compared with heterosexuals of a similar age, have an elevated risk of functional limitations and mental distress and some adverse health behaviors, even when controlling for age, income, and education (Fredriksen-Goldsen et al. 2013c).

While the term LGBT is often used in research, we found distinct variations and unique needs among these subgroups. Older lesbian and bisexual women have higher rates of disability and an elevated risk of obesity and cardiovascular disease compared with older heterosexual women; gay and bisexual older men are at higher risk of poor health and living alone than older heterosexual men (Fredriksen-Goldsen et al. 2013c). Using pooled data from the 2003, 2005, and 2007 California Health Interview Survey (CHIS) of adults 50–70 years old, Wallace and colleagues (2011) also found that lesbian and bisexual women and gay and bisexual men were more likely to live alone compared with heterosexuals and had a greater risk for disability, poor general health, and psychological distress; gay and bisexual older men were also at higher risk for hypertension and diabetes than older heterosexual men. In addition, transgender older adult participants had elevated rates of poor physical health, disability, and depression compared with nontransgender LGB older adult participants in *Caring and Aging with Pride* (Fredriksen-Goldsen et al. 2013a).

Different cohorts experience different historical eras and events, and have differential risks and access to resources. In our *Caring and Aging with Pride* study, we cannot disentangle age, cohort, and period effects because of the cross-sectional design, and although longitudinal designs are not able to fully distinguish between age, cohort, and period effects (Glenn 2005), we can nonetheless begin to examine age group differences among midlife and older LGBT adults as a starting point. Health outcomes among LGBT older adults vary by distinct age groups and these

health-related patterns by age are similar to those found in the general adult population (Blanchflower and Oswald 2008; Blanchflower and Oswald 2009). In general, LGBT older adults aged 80 and older report poorer physical health-related quality of life than younger age groups, including those aged 50–64 and 65–79, and those aged 65–79 report better mental health-related quality of life than those aged 50–64 and those 80 and older (Fredriksen-Goldsen et al. 2015). However, we find a different configuration of resources and risks by distinct age groups (Fredriksen-Goldsen et al. 2011).

Resilience and Resources

Despite a long history of discrimination and marginalization, most LGBT older adults experience good health. In *Caring and Aging with Pride*, we found that approximately three-fourths of LGBT older adult participants report good or excellent health. The personal and social resources available to LGBT older adults, such as disclosure, marriage, partnership, and social support, likely offset some of the challenges older LGBT adults face. Resources are important because, as protective factors, they may buffer against adversity and risk and can be found at individual, family, and community levels.

Disclosure of sexual orientation and gender identity is generally associated with both psychological (Meyer 2003) and social well-being (Kertzner et al. 2009), in part through providing access to social support from other LGBT people and a potential sense of "belongingness." At the individual level, disclosure of sexual orientation or gender identity can buffer the effects of internalized stigma and foster psychological well-being (Meyer 2003). Disclosure to one's primary care physicians also supports good health, as it allows for important discussion about sexual health (American Medical Association 2013). Disclosure may also have a more direct effect on health through modulating important processes of immune system functioning (Kemeny and Schedlowski 2007; Meyer 2003).

Partners and spouses provide a broad range of physical, emotional, and economic benefits to older adults in the general population. Evidence suggests that these benefits generally extend to same-sex couples (Wienke and Hill 2009), especially when such relationships are supported by important others, like family members (Blair and Holmberg 2008). Based on data in *Caring and Aging with Pride*, having a same-sex part-

ner was associated with better general health and less depressive symptomology as compared with being single, after controlling for gender, age, education, income, sexuality, and relationship duration (Williams and Fredriksen-Goldsen 2014). Interestingly, length of time of the relationship did not significantly influence the association between relationship status and health among LGBT older adult participants. However, the specific nature of same-sex relationships may be important. For example, legal marriage but not domestic partnership has a protective effect on midlife and older gay men's health (Wight et al. 2012).

Social networks and social support, reflecting both the structure and function of social relationships, have also been found to attenuate the risk of depression, disability, and poor physical health among LGBT older adults (Fredriksen-Goldsen et al. 2013a; 2013b). The LGBT older adult participants in our study report, on average, a large social network with moderate levels of social support; lesbians and bisexual women report higher levels of social support compared with gay and bisexual men (Kim, Fredriksen-Goldsen, and Hoy-Ellis 2011). In addition to social network size and support, being connected to LGBT communities may provide important resources (Meyer 2003). At the individual level, LGBT people may be able to more positively reappraise their stigmatized identities by making meaningful comparisons with "like" others rather than negative comparisons with heterosexuals. Identification with other LGBT people is also important in the development of a positive group identity. Being able to connect with other LGBT people also provides other important social resources such as having supportive others to turn to when one experiences discrimination (Meyer 2003). In addition to conferring a sense of belonging, which in and of itself has protective effects on mental health (Hagerty et al. 1992), older lesbians, gays, and bisexuals who regularly engage with other lesbians, gays, and bisexuals are less likely to experience loneliness than those who are not (Fokkema and Kuyper 2009).

Like older adults in the general population, the LGBT older age groups in our study, 65–79, and 80 and older, had levels of social support comparable to those aged 50–64 but had smaller social network sizes and lower levels of community connectedness (Fredriksen-Goldsen et al. 2015). Interestingly, in our study, those aged 80 and older are understandably more likely to be receiving informal care than their younger

counterparts in the 50–64 and 65–79 age groups, yet they were equally likely to be providing informal care to others. This is important because, in some contexts, providing social support may actually be more beneficial to well-being than receiving it (Thomas 2010).

Adversity and Risks

Compared with older adults in general, LGBT older adults experience some unique risk factors that are associated with their mental and physical health. Experiences of discrimination and victimization based on sexual orientation and gender identity have consistently been linked to poor physical and mental health (Fredriksen-Goldsen et al. 2013a; 2013b). Experiences of discrimination and the larger structural context can lead to the "social patterning of stress," which not only can result in less availability of resources that buffer stress but can result in greater levels of stress itself (Meyer, Schwartz, and Frost 2008). Stressors can be acute and objective, such as actual experiences of discrimination and victimization; they can also be chronic and more subjective, such as the lived experience of heterosexism by LGBT individuals (Hendricks and Testa 2012; Meyer 2003).

Stigma, a constellation of experiences that include stereotyping, social exclusion, labeling, discrimination, and loss of status that directly result from marginalization due to minority status are considered by some as a "fundamental cause" of population health disparities (Hatzenbuehler, Phelan, and Link 2013). Such risk factors are associated with multiple health outcomes, resulting in limited access to social, economic, and environmental resources that either circumvent risks or attenuate poor health outcomes (Hatzenbuehler et al. 2013). "Inequities in health systematically put groups of people who are already socially disadvantaged ... at further disadvantage with respect to their health; health is essential to ... overcoming other effects of social disadvantage" (Braveman and Gruskin 2003: 254).

This is particularly relevant to LGBT older adults as they are already socially disadvantaged in a heterosexist society (Meyer 2003), and the health disparities that they experience make it more challenging to address their social disadvantage. In addition to its external manifestations (e.g., discrimination and victimization), stigma can also be internalized with additional negative consequences for health. In our study, we found that internalized stigma is linked to poor physical and mental

health outcomes among LGBT older adults (Fredriksen-Goldsen et al. 2013a; 2013b). Because of the recursive nature of the relationship between stigma and expressions of societal heterosexism, for example, victimization and discrimination, with the presence of one increasing the risk for the other (Wolkowitz, Reus, and Mellon 2011), it likely increases the risk of both physical and mental health disparities.

LGBT older adults, as a result of their sexual orientation and/or gender identity, are also often excluded from full participation in society. According to the World Health Organization (WHO), adverse structural contexts can also result in social exclusion, which in turn increases the risk for disease, especially cardiovascular disease (CVD), disability, substance abuse, and social isolation (Wilkinson and Marmot 2003). Social isolation itself has consistently been linked with increased risk of CVD and consequent death, especially among the most isolated (Arthur 2006). Although living alone does not necessarily mean one is socially isolated, it does significantly increase the risk (Cacioppo and Hawkley 2003). Older gay and bisexual men are at particular risk of living alone, which may place them at higher risk of social isolation (Fredriksen-Goldsen et al. 2013c; Wallace et al. 2011). In addition, we have found that gay and bisexual men are at elevated risk of loneliness (Fredriksen-Goldsen et al. 2011).

When examining such risks by age group among LGBT older adults, the degree of internalized stigma is higher for the oldest age groups, those 80 and older, yet lifetime discrimination and degree of identity disclosure is lower than in the 50–64 and 65–79 groups. Since the older age groups are less likely to disclose their sexual orientation, it may be protective in the sense that it resulted in fewer discriminatory experiences in an earlier, more hostile society. Interestingly, the 50–64-year-old age group reports significantly higher levels of loneliness than both the 65–79 and 80 and older age groups, which increases their risk for social isolation and its consequent risks.

Health Behaviors

Health behaviors can adversely affect or promote health. Many chronic conditions are linked to the lack of regular physical activity, excessive drinking, tobacco use, and poor nutrition (CDC and National Center for Chronic Disease Prevention and Health Promotion 2010). In our

study, we found that most LGBT older adult participants engage in regular physical activity (Fredriksen-Goldsen et al. 2011) at rates similar to older adults in the general population (Fredriksen-Goldsen et al. 2013c). Similar to older adults in the general population, the lack of physical activity has been found to be an independent predictor of depression, disability, and poor general health among older lesbian, gay, and bisexual adult participants (Fredriksen-Goldsen et al. 2013b), and is significantly associated with better physical and mental health outcomes among older transgender adults (Fredriksen-Goldsen et al. 2013a).

Tobacco use and excessive drinking are leading causes of preventable morbidity and mortality in the United States (CDC 2010). Lesbian, gay, and bisexual older adults have higher rates of both smoking and excessive drinking than heterosexual older adults (Fredriksen-Goldsen et al. 2013c). Substance abuse refers to both the use of illicit substances and the use of legal substances in a manner not prescribed by a physician. Because of age-related physiological changes, substance abuse may have an even stronger effect on the health and functioning of older adults (Substance Abuse and Mental Health Services Administration 2010). A similar trend has been observed among lesbian, gay, and bisexual midlife adults who appear to have more serious problems with substance abuse compared with previous generations (Jessup and Dibble 2012). Approximately 5 percent of older adults in the general population reported past-year illicit substance use (Substance Abuse and Mental Health Services Administration and Office of Applied Studies 2009). In our study, 12 percent of the LGBT older adult participants reported using nonprescribed drugs within the previous 12 months, and another 9 percent took prescription drugs in a manner other than prescribed by their physician, including both over and under use (Fredriksen-Goldsen et al. 2011).

LGBT midlife and older adults also experience some unique barriers to health care. Eight percent fear accessing health care inside the LGBT community and nearly twice as many (15 percent) fear accessing health care in the general community. In fact, 13 percent reported they received inferior health care or were denied health care as a result of their sexual orientation or gender identity. In addition, 7 percent of participants have been unable to see a doctor or obtain needed medications because of cost. Although older lesbian and bisexual women are less

likely than older heterosexual women to have had a mammogram during the preceding year, they are more likely to have been tested for HIV; older gay and bisexual men are also more likely to have been tested for HIV and vaccinated for influenza compared with older heterosexual men (Fredriksen-Goldsen et al. 2013c).

When examining differences in health behaviors among LGBT older adults by age group, we see trends similar to the general population. Among LGBT adults, the older age groups, those aged 65–79 and 80 and older, are less likely to engage in substance use and more likely to receive a routine health check-up compared with the 50–64 age group. While these older age groups are also less likely to engage in vigorous physical activities, they continue to engage in wellness activities at the same rate as the younger age groups.

Background Characteristics

The sociodemographic profile of LGBT older adults, including gender, race/ethnicity, income, and education, are associated with physical and mental health similar to older adults in the general population. For a full description of the original *Caring and Aging with Pride* sample; extensive tables showing risk, protective, and other factors; and significance-testing by sexual orientation, gender, gender identity, age group, and race/ethnicity, see Fredriksen-Goldsen et al. (2011). In the study, women had poorer physical and mental health and higher rates of disability than men (Fredriksen-Goldsen et al. 2011). On the other hand, they also evidence some additional resources, including higher levels of disclosure and social support combined with lower levels of discrimination and victimization. Compared with men, women in this study also report lower levels of stigma, are more connected to their communities, and are more likely to participate in spiritual or religious activities. In comparisons by gender identity, transgender older adult participants have poorer physical and mental health than their nontransgender counterparts, even after controlling for age, income, and education (Fredriksen-Goldsen et al. 2011). They also experience higher levels of discrimination, victimization, and stigma, and have lower levels of disclosure, social support, and community connectedness. Yet, they are more likely to participate in spiritual or religious activities, which may be linked to race and ethnicity, since a significant

proportion of the transgender participants in the study are Hispanic (Fredriksen-Goldsen et al. 2011).

When examining differences by race and ethnicity, we also found that, compared with non-Hispanic white LGBT older adults, both LGBT Hispanic and Native American older adults are at elevated risk of poor physical and mental health outcomes, combined with higher levels of disability, victimization, discrimination, and stigma as well as less access to resources such as income and other types of support.

Several recent studies have documented that sexual minorities have higher levels of education, but equivalent or lower levels of income. Despite significantly higher levels of education and higher rates of employment, older lesbian and bisexual women's incomes are similar to those of older heterosexual women (Fredriksen-Goldsen et al. 2013c). However, older gay and bisexual men have significantly higher levels of education and similar rates of employment to older heterosexual men, but their incomes do not differ (Fredriksen-Goldsen et al. 2013c). A meta-analysis by The Williams Institute indicated that equally qualified gay and bisexual men have incomes that are 10 percent to 32 percent less than heterosexual men (Badgett et al. 2007), which will have important repercussions for retirement and aging.

Moving Forward: Implications for Services, Policy, and Research

LGBT older adults are a health disparate population. It is imperative to identify and establish mechanisms of risk and protection that may influence their health trajectories in ways that may differ from the general older adult population, and to recognize that their risk profiles may differ by age and cohort as well as other sociodemographic characteristics, such as gender. Because structural and societal risks and individual health behaviors interact through a variety of mechanisms, a variety of approaches are necessary to promote health equity for LGBT older adults.

Both upstream and downstream interventions are needed. Since smoking, excessive drinking, poor nutrition, and lack of physical activity significantly increase the risk for developing chronic health conditions and poor health (CDC and National Center for Chronic Disease Prevention and Health Promotion 2010), they are undoubtedly

important points for intervention and prevention efforts. Yet, it is also necessary to understand how structural barriers may thwart such efforts. For example, LGBT adults often use tobacco, alcohol, and other substances to alleviate stress (Jessup and Dibble 2012). Supportive social networks can also be instrumental in making positive behavioral changes (Wilkinson and Marmot 2003), such as smoking cessation and substance use reduction. Targeted efforts to bolster the social networks of LGBT adults aged 50–64 years old may be particularly germane, as they smoke, drink, and engage in illicit substance use at higher rates; report more loneliness; and have higher levels of suicidal ideation than their LGBT peers aged 65 and older. In addition to individual interventions, community-level interventions to address social exclusion are needed (Wilkinson and Marmot 2003). At the very time in their lives when LGBT older adults are likely to experience an increased need for community-based supports, they may be less likely to access them out of fear of discrimination and victimization. Aging and health services need to address prejudice and bias among both staff and clientele. The U.S. Department of Health and Human Services has issued directives clarifying that the Affordable Care Act (ACA) prohibits any agency, service, or program that receives federal funding from discriminating on the basis of sexual orientation or gender identity under the "sex" and "sex stereotyping" prohibitions of Title VII of the 1964 Civil Rights Act (Bradford and Mayer 2014).

LGBT organizations should also engage in targeted educational outreach efforts to ensure that LGBT older adults are aware of their rights and mechanisms for redress under the ACA. Actively soliciting LGBT older adults to serve on community advisory boards and as consumers can also be an effective step toward addressing the need to create culturally responsive aging and health services. In addition, in-depth and systematic reviews of agency policies and procedures can help identify those that exclude and marginalize LGBT older adults. It is essential that intake forms and all other materials be reviewed and modified as necessary to include questions regarding sexual orientation and gender identity as part of gathering sociodemographic information.

Just as mainstream aging agencies need to recognize and adapt to the reality that they may be excluding *LGBT* older adults, services and programs in LGBT communities must recognize and address the fact that they may not be creating a welcoming environment for LGBT *older adults*

and their families. For example, mainstream aging agencies should assess whether the images in their printed materials (e.g., fliers, newsletters) and in their lobbies, waiting areas, and offices (e.g., magazines, artwork) depict LGBT couples and individuals and/or symbols that are easily recognizable and meaningful to LGBT people (e.g., the rainbow flag). Such visual signs and symbols are visual cues that LGBT older adults are recognized and will be affirmed. Services and programs in LGBT communities should not only examine whether older LGBT adults are depicted in their materials but also how their services and programs could be successfully expanded or revised to specifically address the needs of LGBT adults. Programs that foster social networks and physical activities among LGBT older adults are needed in mainstream aging agencies and in LGBT communities. In addition to providing direct mental and physical health benefits, these practices also represent upstream interventions in that they are steps toward interrupting the stigma of heterosexism and ageism, both of which contribute to health disparities.

Because LGBT older adults generally provide informal care to and receive informal care from one another (Muraco and Fredriksen-Goldsen 2011), services and programs must be tailored to support the full range of caregiving relationships, which may be particularly challenging as these relationships may not be legal or biological in nature, in contrast to those of the general older adult population. This not only places additional burdens on LGBT older adult caregivers and care recipients in terms of ability to make legal decisions regarding care, but may also deny important direct and ancillary benefits that other caregivers and those receiving care enjoy. Furthermore, LGBT adults aged 80 and older are just as likely as their younger peers to be providing informal care, and are more likely to be receiving care. Hence, care planning for LGBT older adults, especially those aged 80 and older, should assess any need for respite care when simultaneously assessing other types of care needed. The LGBT community has a rich history of advocating for and supporting some of its most vulnerable and disenfranchised members, as was evident during the height of the U.S. AIDS pandemic. If similarly applied, such political activism and community organizing would directly benefit the older members of the LGBT community and could also provide a model of caring that would benefit the general population, especially in light of the projected rapid expansion in both size and diversity of the older adult population in the coming decades.

Socially integrated relationships appear to play a role in better health for LGB midlife and older adults (Williams and Fredriksen-Goldsen 2014). Yet, not all LGBT older adults are able to participate fully in society. On June 26, 2015 in *Obergefell v. Hodges* (2015), the Supreme Court of the United States ruled that same-sex couples have the constitutional right to full legal marriage and that all states must recognize those marriages as such. However, legal marriage in and of itself does not bestow full protection under the law. Explicit and comprehensive protections for LGBT people in employment and public accommodations are still lacking in 31 states (Human Rights Campaign 2015). There are no definitive, blanket federal protections against discrimination in public accommodations based on sexual orientation or gender identity. Federal employees and contractors are barred from discriminating based on sexual orientation or gender identity, yet many federal entities, such as the Department of Housing and Urban Development and the Equal Employment Opportunity Commission, are interpreting sexual orientation and gender identity as protected classes under the "sex" and "sex stereotypes" prohibitions in Title VII of the 1964 Civil Rights Act. The Equality Act, H.R. 3185 that would amend the Civil Rights Act to include sexual orientation and gender identity was introduced in 2015, but currently stands almost no chance of being passed. There is a growing backlash against LGBT people in the wake of marriage equality. Increasingly, legislation is being proposed and passed across the country that would exempt individuals and groups in both the public and private sectors from laws and statutes that do protect LGBT people under the guise of religious freedom. Currently, 25 states have pending or enacted bills that allow legal discrimination against LGBT people based on religious beliefs, including refusing to recognize or perform same-sex marriages, provide health-care services, or allow LGBT people to adopt or provide foster care to children (American Civil Liberties Union 2015). Due to a long history of institutionalized discrimination and the ongoing discourse around religious freedom, it will be some time before LGBT Americans have the same legal rights as heterosexuals.

Although health disparities have been documented among LGBT people, large gaps remain in our knowledge about LGBT health and well-being. To date, there are limited data available to monitor health in these communities. In fact, most health surveys do not include sexual orientation or gender identity questions. One important step has been

made with the inclusion of a sexual orientation question recently added to the National Health Interview Survey. Other national surveys such as the Health and Retirement Study (HRS), the American Community Survey (ACS), and the Behavioral Risk Factor Surveillance Surveys (BRFSS) should routinely include questions related to both sexual orientation and gender identity for all participants. What little is known about transgender health comes primarily from large community-based surveys (Fredriksen-Goldsen et al. 2013a; Grant et al. 2011), which means that findings are not generalizable. Routinely gathering sexual orientation and gender identity data in medical records will also significantly enhance our knowledge of LGBT health (Institute of Medicine 2011). In particular, research is needed that better differentiates the unique experiences and needs of older compared with younger transgender adults.

There is every indication that LGBT older adults are just as heterogeneous as their heterosexual counterparts and research should reflect this. Rather than treating age solely as a confounder, researchers should consider it as an independent variable. Studies are needed to further elaborate similarities and differences *within* LGBT older adult cohorts (e.g., 50–64, 65–79, 80 and older) and *between* their respective younger LGBT and midlife and older LGBT cohorts (e.g., younger than 50 vs. 50 and older), and their heterosexual peers of similar age. We also need longitudinal studies that follow LGBT people from adolescence through old age, as today's younger LGBT people are tomorrow's midlife and older LGBT adults.

Although resilient, LGBT older adults are an at-risk population, evidencing significant health disparities. Additional research and community-based interventions are needed to promote health equity and the full health potential of LGBT midlife and older adults. While *Caring and Aging with Pride* provides important new information about the health, aging, and well-being of LGBT midlife and older adults, it is cross-sectional and the findings are not generalizable. Although longitudinal studies cannot completely disentangle age, period, and cohort effects, they are needed in order to work toward clarifying the temporal order between risk and protective factors and to better understand the full range of health outcomes and health trajectories in these communities. Such studies will be vital in disentangling age, period, and cohort effects. Most studies to date have relied heavily on self-reported measures, with no functional or biological measures. The next wave of LGBT health and aging studies must more comprehensively address the diversity and subgroups within

these communities as well as identify underlying mechanisms of risk to design and test the effectiveness of culturally appropriate interventions. Such efforts will affirm LGBT older adults, and enhance our understanding of diversity in our aging world.

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