Unique challenges faced by the LGBT community as they age

Lesbian, gay, bisexual, and transgender (LGBT) older adults are often described as an “invisible” or “hidden” segment of the aging population (Brotman, Ryan, & Cormier, 2003; de Vries & Blando, 2004; Jenkins Morales et al., in press). This invisibility is multiply determined and derives from both stigma and neglect (as reported across the array of mental and physical health settings, National Senior Citizen’s Law Center, 2011) as well as concealment or being “in the closet” (an understandable response to having endured being labeled as anti-family and immoral by religious groups and a security risk or morale threat by military leaders, e.g., Kochman, 1997). Croghan et al (in press) note that a consequence of this invisibility is disregard for the needs of LGBT older adults, which are both different and more numerous than among the general population, as noted below.

Owing to this stigma and discrimination, changing norms and a variety of other social conditions, estimates of the prevalence of LGBT persons in general, and older persons in particular, vary widely. Among the best estimates (from General Social Surveys and other such efforts), are that about 4 to 6 percent of the adult population identify as LGBT (Gates & Newport, 2013; Institute of Medicine, 2011; MetLife, 2010).

Research has begun to explore the lives of these disfranchised older adults revealing a variety of demographic and related health conditions, most of which have stigma at their base (de Vries, 2013). For example, relative to heterosexual men and women of comparable ages, LGBT older adults are more likely to live alone (three times more likely for gay men 60% of whom live alone) and one and a half times more likely for lesbians (30%); gay men are as much as three times less likely to be partnered (25% have partners) and lesbians about half as likely (37%) as their heterosexual counterparts (Adelman et al., 2004; MetLife, 2010; Wallace et al., 2011) and both are less likely to have children (about five times less likely in one recent large, urban study (Fredriksen-Goldsen et al., 2013) and, among the 15% who had children over 60% reported that their children were not available to assist them. Sadly and unsurprisingly, LGBT older adults report high rates of loneliness and isolation (Kuyper & Fokkema, 2010).

Recent research has revealed that relative to older heterosexual adults, LGBT older persons have significantly higher rates of both psychological and physical health conditions, including depression (with rates almost twice as high as heterosexuals—Mills et al., 2004), suicidal beliefs and actions (Grossman et al., 2001), and exposure to violence (Fredriksen-Goldsen et al., 2011). Alcohol and cigarettes have been found to be used in greater proportions among LGBT older adults than among comparably aged heterosexual persons (Gruskin et al., 2007), often interpreted as a response to stigma (de Vries, 2013). Several studies have found higher rates of cancer among older lesbians and gay men (Chin-Hong et al., 2004; Valanis et al., 2000) and much higher rates of HIV (Effros et al., 2008). Importantly, in one recent study (and replicated in several smaller studies),
almost half of a large sample of community-dwelling older LGBT persons reported a disability (Fredriksen-Goldsen et al., 2011).

These many serious and life-limiting health conditions are exacerbated by the demographic characteristics referenced above, reflecting a potential isolation with direct and important caregiving implications. That is, much research reveals a heteronormative pattern of support seeking (e.g., the Hierarchical Compensatory Model, Cantor & Mayor, 1978): care is both expected and first sought from spouses, then adult children or other family, then more distant kin and friends, followed by formal organizations and services. Substantial research notes the suspicion and fear with which older LGBT adults approach formal (health care) institutions (National Senior Citizens Law Center, 2011) and consequently delay seeking formal care (MetLife, 2010). Conversations about care are rare but are largely family-centered. By virtue of the demographics reported above, and all that flows into and from these characteristics, LGBT persons are less likely/able to turn to kin for support and are even less likely to have conversations about care; less than half of a national sample of LGBT boomers had completed advance directives (MetLife, 2010). Friends are both more prominent and influential in the lives of LGBT persons (de Vries & Megathlin, 2009; MetLife, 2010). LGBT persons turn to friends in greater proportions in times of need, for confiding, emotional support and assistance, but friendship networks lack the structure and support of kinship systems (Barker, 2002).

The above issues point to the stress and stigma that characterize LGBT later life with deleterious effects on social connections, mental and physical health, and preparations for end of life.

References


National Senior Citizens Law Center (2011). *LGBT older adults in long-term care facilities: Stories from the field.*
