

Counseling Older Adults in LGBT Communities

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Consideration of older adult lesbian, gay, bisexual, and transgender (LGBT) persons in gerontological research is lacking, leaving professional counselors without a substantive bridge with which to connect resources with treatment planning when working with sexual minorities. Therefore, presented here is an overview of aging research related to older adult LGBT individuals. The importance of individuality among LGBT individuals and suggestions for professional counselors who work with both individuals and couples in these populations also are presented.

Keywords: LGBT, older adults, gerontology, aging research, individuality

Multidisciplinary in nature, *gerontology* encompasses the study of dynamic processes of aging as experienced on the social, psychological, and biological levels (Hooyman & Kiyak, 2008). Knowledge of gerontology therefore enables professional counselors to work more effectively with older clients by facilitating understanding of their worldview. Professional counselors thus are better able to contextualize how aging itself is not the pathology, but rather the context that influences other aspects of the client's life.

Due to advances in medical care and quality of life, the average lifespan in the U.S. is being prolonged and the percentage of those reaching old age is increasing dramatically (Dobrof, 2001). According to recent U.S. Census data (2008), the number of Americans aged 85 years and older will increase from 5.4 million in 2008 to 19 million by the year 2050. In addition, about 1 in 5 U.S. residents will be age 65 or older by 2030. It is not uncommon in professional literature and research to differentiate old age into categories, such as the *young old*, typically between 60 to 79, and the *old old*, typically 80 and above, to capture more accurate developmental data at different stages of the life cycle (Grossman, 2008; McFarland & Sanders, 2003; Quam, 1993; Quam, 2004; Quam & Whitford, 2007). Although relatively arbitrary, such categories do point to the fact that there are developmental differences even among older adults.

Older adult sexual minorities have been relatively ignored in gerontological research (Apuzzo, 2001; Cook-Daniels, 1997; Grossman, 2008; Kimmel, 1979; Orel, 2004; Quam, 2004). It is estimated that there are between 1 and 3 million individuals in the U.S. over age 65 who identify as lesbian, gay, bisexual, or transgender (LGBT) (Jackson, Johnson, & Roberts, 2008; McFarland & Sanders, 2003), and that number is expected to increase substantially in the next 15 years (Penn, 2004). Unfortunately, whether because of discriminatory bias against LGBT individuals or the invisibility of sexual identity within older adult populations in the larger society, most professional counselors find themselves lacking in general knowledge about this growing population and therefore ill-equipped to provide professional services for them.

Older adults, whether heterosexual or part of the LGBT community, confront many concerns about aging, including financial matters, health, companionship, independence (Quam & Whitford, 1992), loss, and residence concerns (MetLife, 2006). All older adults also face issues and stereotypes surrounding ageism (Wright & Canetto, 2009), including discriminatory attitudes and behaviors against older persons (Hooyman & Kiyak, 2008). However, ageism as experienced in LGBT communities has the additional impact of making a stigmatized group feel even more of a minority (Brown, Alley, Sarosy, Quarto, & Cook, 2001; Drumm, 2005; Jones, 2001; Jones & Pugh, 2005; Kimmel, Rose, Orel, & Greene, 2006; Meris, 2001).

Additional concerns unique to older adult LGBT individuals include the ability to make legal decisions for each other as couples/partners, lack of support from family who might not recognize or respect their sexuality, and homophobic discrimination in healthcare and other services. Older adult LGBT persons often face unparalleled discrimination and harassment in residential care facilities (Johnson, Jackson, Arnette, & Koffman, 2005; Phillips & Marks, 2008). While elder abuse is recognized as a significant problem among older adults in general, unfortunately there is a deficiency of

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specific knowledge about abuse for older adult LGBT persons (Moore, 2000). Thus, in the vast majority of situations, mainstream services for older adults are not meeting the specific and unique needs of the older adult LGBT population (Slusher, Mayer, & Dunkle, 1996).

Older adult LGBT individuals have lived through distinctively oppressive social climates for sexual minorities compared to more recent generations. Their early developmental years were marked by a typically homophobic culture in which homosexuality was overtly and profoundly admonished, and included messages from national and local leaders that their sexuality was immoral, pathological, and often illegal. For example, the old old grew up in an era during which President Eisenhower ordered all homosexuals to be fired from government jobs and Senator McCarthy sought to ‘expose’ communists and homosexuals (Kimmel, 2002). Without a more organized movement in place in that era to combat the rampant homophobia and negative stereotyping, blatant fear and dislike of homosexuality was seen in nearly all political, educational, and religious institutions. Indeed, the general lack of support for LGBT individuals in religious institutions continues today, leaving many in the position of a forced choice between two fundamental components of their sense of self: spirituality and sexuality. “In turn, this conflict can manifest itself through internalized disorders, such as depression, or through externalized disorders, such as risky or suicidal behavior” (Mabey, 2007, p. 226). However, it is important for professional counselors to be aware of the distinction many older adult LGBT persons make between spirituality and religiosity; religious dogma against homosexuality does not prevent many LGBT individuals from maintaining a strong spiritual identity (Mabey, 2007; Orel, 2004).

The young old, though, became adults during a time of more relatively progressive changes in society. The Stonewall riots in Greenwich Village in 1969, in which gay and transgender individuals physically fought back against unjust police harassment, marked a milestone in what would eventually become the modern gay rights movement. In the mid-1970s, homosexuality was finally declassified as a mental disorder within both the American psychiatric and psychological professional communities (but only after decades of miseducating medical and mental health professionals about the pathologic nature of sexual minorities).

As professional counselors work with an aging LGBT population, it is important to consider this historically negative climate which shaped an individual’s experiences with, and impressions of, her or his own sexual identity (Berger, 1982). For the older adult LGBT individual, consequently, there might exist a sense of internalized homophobia (D’Augelli, Grossman, Hershberger, & O’Connell, 2001; Heaphy, 2007; Porter, Russell, & Sullivan, 2004) that contributes to nonparticipation in LGBT-supportive services and associated diminished overall mental health. These individuals also are less likely to seek any general health services for fear of having to disclose their sexual orientation to a possibly homophobic provider (Brotman, Ryan, & Cormier, R., 2003; Grossman, D’Augelli, & Dragowski, 2007; Sussman-Skalka, 2001). For example, refer to Zodikoff (2006) for vignettes that highlight unique aspects of social work practice with a diverse and aging LGBT population.

Aging and Individuality

Professional counselors should recognize that an older adult LGBT individual does not belong to one homogenous group within the LGBT acronym. For example, a gay youth living in New York City at the time of the Stonewall Riots will have experienced the movement in vastly different ways than, say, a gay youth then living in the rural Midwest. Similarly, a transgender individual involved in the Stonewall Riots will have faced different experiences than a gay male in those same riots because of the greater concealment of transgender individuals. Cook-Daniels (1997) wrote, “Lesbian and Gay male elders have been called an ‘invisible’ population (Cruikshank, 1991). If they are invisible, then transgendered elders have been inconceivable” (p. 35).

Transgender older adults also face unique challenges apart from those who are lesbian, gay, or bisexual (Cook-Daniels, 2006). For example, health concerns for those transitioning from male to female (MTF) or female to male (FTM) are greater because surgeries become more complicated with age. However, there has been a significant increase in the number of those willing to face the risk of transitioning in later life because of vastly improved methods of electronic communication about options, new research, and medical procedures (Cook-Daniels, 2006).

Another challenge to older adult transgender individuals is that most older adults in society, including gay and lesbian older adults, have well-established social roles and relationships. Thus, MTF or FTM transitioning becomes more difficult

with age because of the need for changed manners of speech and gesticulations. Legal issues include additional unique challenges as a change in gender is often associated with changed governmental benefits. For example, a formerly heterosexual marriage might be seen as an illegal same-sex marriage after one spouse transitions, and then formerly anticipated benefits, such as Social Security, might be revoked.

As professional counselors work with the older adult transgender population, there are several important aspects about this community to be considered in treatment planning (Cook-Daniels, 2006). First, although transphobia in the medical community and healthcare facilities has not been adequately researched, it is well-documented (Donovan, 2001). Therefore, making effective referrals necessitates that the new service provider be familiar and comfortable with the transgender population. Professional counselors also should understand the roadmap for individuals who are transitioning, and in particular how they need to be declared mentally fit as well as diagnosed with Gender Identity Disorder before any treatment for transitioning may commence. Professional counselors also should understand that persons in MTF or FTM are often perceived to be, "...mentally ill until proven otherwise, and they are fearful and angry that—to a degree that is rivaled perhaps only by prisoners and the severely domestically abused—their life choices are under someone else's control" (Cook-Daniels, 2006, p. 25). To the extent that a transgender person holds this perspective, it might interfere with his or her level of comfort in seeking the services of a mental health professional at all.

Transgendered individuals also cannot control the coming-out process of their gender identity because visual or auditory cues may expose their status, and therefore they are left open to the opinions and reactions of others they encounter. Thus, it is important for professional counselors to assess their own comfort levels, and meeting transgender individuals or volunteering in an organization that serves this population is a great way to increase familiarity with and knowledge about this group. It also is important to recognize that transgendered individuals face financial constraints that are usually greater than those typically encountered by other gay, lesbian, or bisexual elders due to hormone medication or surgical procedures that are usually not covered by insurance. Therefore, as with other clients experiencing financial constraints, professional counselors might employ a sliding-fee scale depending on their client's stage of transition and/or individual circumstances.

Bisexual individuals also experience a sense of invisibility within the LGBT community. As another underrepresented group in professional research literature, the needs and experiences of bisexual older adults also are often misunderstood. Professional counselors likely will work with bisexual clients during their careers, and should approach treatment without the erroneous assumption that sexuality is necessarily dichotomous (Dworkin, 2006).

Ageism typically precludes recognizing the sexuality of older adults (Hooyman & Kiyak, 2008). However, it is an important element. Consider a professional counselor who meets an older adult client who is happily married to a member of the opposite sex. That counselor likely will not consider that the client may in fact be bisexual—but it may be the case. Indeed, coming out as bisexual during a heretofore heterosexual marriage is the point at which a professional counselor might most be needed as issues of intimacy and restructuring of familial dynamics are addressed.

There also is the myth of the impossibility of monogamous relationships for bisexual individuals that should be considered by professional counselors (Dworkin, 2006). Simply because a person has the capacity for attraction and/or commitment to both males and females does not mean that the individual is unfulfilled with a monogamous relationship or that polyamorous relationships are necessarily seen as negative.

Aging Research and Identity

Differences among individuals within the "LGBT" acronym highlight the necessity for a professional counselor to understand the complex nature of identity. Through a shared history, current activism, and support networks, individuals within the LGBT community have much in common with one another. However, they also have differences. In building rapport with an older adult client, a professional counselor should recognize these differences (beyond commonly understood stereotypes). For an older adult LGBT client, having a well-informed professional counselor is essential to relationship-building and establishing trust, i.e., a comfortable environment in which LGBT history can be addressed and acknowledged.

Comprised of persons of every nationality, socioeconomic status, gender, ability level, race and ethnicity, the older adult LGBT population cannot be grouped or treated as one cohesive category. Unfortunately, research about LGBT elders is still underrepresented in gerontological literature, and representative samples of populations within that body of research are even more limited (Berger & Kelly, 2001; Butler, 2006; Grossman, D'Augelli & Hershberger, 2000; Jackson, et al., 2008; Kimmel, 2002; Quam & Whitford, 1992). Indeed, because of a variety of factors, such as “closeted” older adults and the lack of organized LGBT communities in some areas, no economically feasible method is available to generate a random sample of older LGB(T) individuals (Grossman, et al., 2000). Professional counselors must also consider this limitation when reviewing research, and how a significant number of studies have been conducted with LGBT individuals with limited sample sizes (and who primarily were Caucasian, highly educated, affluent, self-identified, younger, male individuals living in urban areas) (Dworkin, 2006; Grossman, D'Augelli, & O'Connell, 2001; Hash, 2006; McFarland, & Sanders, 2003; Porter, et al., 2004). Within the professional research and literature on older adult LGBT individuals, there exists a substantial gap in representation of people of color, the old old, and those living in rural areas.

Professional counselors should inquire of each older adult LGBT client about level of identification with an LGBT identity or community. Indeed, a professional counselor may be better educated about LGBT history and circumstances than the client, and therefore may be able to facilitate the older adult LGBT client's identity development. Indeed, it is rare for an older adult LGBT individual to have had LGBT parents, and therefore they are not necessarily taught this cultural history or coping strategies for overcoming homophobia, biphobia, or transphobia in the traditional family setting. Regardless, the ability of a professional counselor to access such information during a session is an important skill for relationship-building and even for educating the client regarding homework or making referrals.

As professional counselors consider the impact of an LGBT identity for the older adult individual, it also is important to not view that identity as necessarily problematic (Berger, 1982). In fact, researchers point to the idea of “crisis competence,” in which the coming-out process enables the individual to develop a competency for dealing with other crises in the lifespan, including difficulties associated with the adjustment to aging (Heaphy, 2007; Kimmel, 2002; McFarland & Sanders, 2003; MetLife, 2006; Morrow, 2001; Quam, 1993).

Additional Skills for Professional Counselors

Sometimes an older adult individual in the LGBT community has difficulty coping with the stressors of homophobia and coming-out, and professional counselors might witness psychological distress or unhealthy behaviors. Kimmel (2002) outlines suggestions that can be adapted by mental health professionals to enhance the development of crisis competency and combat maladaptive thoughts and behaviors with this population. The suggestions include to:

- Aid the client to discover any familial or peer support.
- Identify positive role models locally or nationally that embody characteristics to which the client would aspire.
- Practice the use of effective coping skills.
- Assist in managing the integration of their multiple identities to enhance their sense of self.

Because the number of older adult individuals in the U.S. is expected to increase dramatically in the next 20 to 50 years, the number of older adult LGBT individuals will continue to grow as well. Professional counselors, working with these often misunderstood populations, face the additional challenge of treating LGBT elders with limited research or experience. Quam, Knochel, Dziengel, and Whitford, (2008) offer practical suggestions for working with same-sex couples that are adapted for work with older adult LGBT individuals:

- Your older adult client may define “family” as close friends who have assumed the role of absent families of origin. These fictive kin must be treated with the same respect as other family members.
- Because of anti-LGBT attitudes, your older adult client's biological or adoptive family may not be providing elder care. This care might instead be provided by fictive kin or not at all.
- Your older adult client might also be a caregiver for another elderly individual, especially as fictive kin play an important role in LGBT communities and caregiving.
- Your older adult client may have biological or adoptive children.
- Be knowledgeable about legal protections such as a will, power of attorney and a health care directive, as there are limited benefits for same sex couples (being denied visitation rights in a hospital when their partner is injured or gravely ill is a possibility).
- Confidentiality is essential when working with an older adult LGBT individual, specifically because of realistic

fears about anti-LGBT attitudes in the medical field or treatment facilities. Therefore, disclosing your client's sexual orientation without permission, even to another LGBT individual, should be strictly avoided.

- Familiarize yourself with older adult LGBT services and communities. An example is SAGE (Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders), a comprehensive social service agency with chapters across the country (<http://www.sageusa.org>).

As professional counselors continue to balance a scholar-practitioner role, increased research and experience with LGBT older adults and their aging will promote and elevate the counseling profession. It also will serve to enrich the lives of millions of LGBT older adults and their supporters. Both historically and in contemporary times, the counseling profession thrives as a fertile ground for pioneering and ground-breaking research; LGBT aging represents a generally underexplored but vital new challenge. Indeed, the dynamic and diverse nature of older adult LGBT communities provides opportunity for expanding academic inquiry and new and innovative treatment modalities in the counseling profession.

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