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Guest Editor's Message: Geriatric Care Management with Sexual Minorities

by Sandra S. Butler, Ph.D.

The elder population of this country is very diverse. Of all groups, older adults are perhaps the most heterogeneous. Providing quality care to an elder client requires sensitivity to that individual's unique needs, culture, and life experiences. As care providers, we have an obligation to become knowledgeable about the diversity among the elders with whom we work; diversity based on class, race, gender, ability, religion, ethnicity, and sexual orientation. This issue of the *GCM Journal* is devoted to the topic of gay, lesbian, bisexual, and transgender (GLBT) elders. The primary goal is to sensitize readers to the experiences and needs of GLBT seniors and to challenge heterosexist assumptions—assumptions that deny and stigmatize GLBT elders' identity, relationships and community.

There is considerable diversity within the GLBT community itself. Lesbian, gay, bisexual, and transgender elders vary in socio-demographic characteristics such as cultural, ethnic or racial identity, physical ability, income, education, and place of residence. "They are also diverse in the degree to which their LGBT identities are central to their self-definition, their level of affiliation with other LGBT people, and their rejection or acceptance of societal stereotypes and prejudice" (Meyer, 2001, p. 856). Despite these differences, GLBT individuals of all ages share experiences related to stigma, rejection, discrimination, and, at times, violence. In most parts of the United States (though selected cities, states, and businesses have nondiscrimination ordinances, laws and clauses) it is legal to discriminate against GLBT people in housing, employment and basic civil rights. In 16 states, archaic sodomy laws continue to brand GLBT individuals as criminal despite ongoing efforts to repeal these statutes (Meyer, 2001).

Since the Stonewall riots in 1969 (a famous demonstration against police harassment of patrons at a New York City gay bar) and the birth of a the Gay Liberation Movement in the 1970s, the experience of being gay or lesbian has dramatically changed. Prior to 1973, homosexuality was labeled a disease by the American

Psychological Association and GLBT individuals were considered sick and immoral. Many elder GLBT individuals spent their earlier lives in constant fear of being discovered, and consequently they constructed elaborate systems for maintaining their privacy and remaining in the closet. This required considerable emotional and psychological energy (Barranti & Cohen, 2000). Now in their senior years, many of these individuals are unlikely to "come out" to their health care providers due to their early life experiences and their ongoing, realistic perceptions of societal homophobia (defined as the irrational fear of homosexuality) and heterosexism in society.

Similar to all older adults, GLBT elders face pervasive ageism in our society. Unfortunately, they also face ageism within the GLBT community itself. Gay culture has been guilty of being particularly youth focused; what is old has been seen as less attractive and less worthy than what is young. Thus GLBT elders become "twice hidden." First, they are invisible due to both heterosexism in the larger, often unwelcoming, society and secondly to ageism within their previously safe havens in the GLBT community (Blando, 2001). Consequently, GLBT elders may not feel comfortable in either traditional agencies serving older adults or GLBT community organizations. Yet, as GLBT seniors grow older and increasingly frail, they may be forced to have more contact with heterosexist institutions. For some, the fear of experiencing homophobic or heterosexist attitudes may prevent them from seeking needed assistance, placing them at risk for decreased quality of life, self-neglect and increased mortality risk (Senior Health Resources, undated). Moreover, GLBT elders are more likely to live alone than others in their age cohort and thus may be in need of special attention as "older adults who live alone are more likely to live in poverty, have poor nutrition, feel depressed, and eventually move into an institution" (AoA, 2001, p. 2).

Despite the greater likelihood of living alone in old age, it is important to point out that the myth depicting

GLBT elders as leading lonely, isolated lives is largely untrue. In fact, there are several reasons why GLBT individuals may experience fewer difficulties with aging than their heterosexual counterparts. Barranti and Cohen (2000) suggest several factors that could account for this comparative ease with the aging process:

- ♦ Coping skills developed through the process of accepting their sexual identity may help GLBT seniors in the acceptance of aging.
- ♦ Skills developed through the coming out process and the management of the social perception of "difference" throughout life prepares GLBT seniors for society's perceptions of old people in a youth-oriented society.
- ♦ The stigma of being old is often experienced as less severe than the stigma, of being "queer" that GLBT seniors faced in their youth.
- ♦ In part due to rejections either by families of origin or procreation, GLBT individuals often create "families of choice" that are able to provide extensive social support in times of need.
- ♦ Greater flexibility in gender roles exhibited by GLBT individuals can be helpful in the aging process.

Thus GLBT elders, while facing some unique challenges in our homophobic and heterosexist society, are also very resilient and may even have some advantages over their non-GLBT counterparts in coping with pervasive ageism. Making geriatric care more accessible and sensitive to GLBT elders is not unlike making services more welcoming for any number of oppressed groups in that it can be challenging, but getting it right is rewarding (Smith & Calvert, 2001). In this special issue of the *GCM Journal*, a group of experts in the field of GLBT aging broaden our understanding of geriatric care for GLBT elders. Each of the following articles provides us with greater insight on how to "get it right."

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Sean Cahill, Director of the Policy Institute of the National Gay and Lesbian Task Force and co-author of the seminal publication *Outing Age*, sets the stage for the subsequent four articles by outlining the significant long-term care issues facing GLBT seniors. He provides an informative discussion on some of the key policy concerns for this population including unequal treatment under retirement income support programs, senior housing issues, and particular barriers related to caregiving and health care. He advocates for increased training in the particular issues facing GLBT elders for all the professionals entrusted with their care and for more research on this population's unique caregiving needs.

Tara Healy draws on both her practice experience as a clinical social worker and her own research with older lesbians in her exploration of culturally competent practice with elderly lesbians. She vividly portrays the struggles of elderly lesbians in a heterosexist world and how this manifests itself in the health care environment. She concludes with a comprehensive and extremely helpful set of guidelines for culturally sensitive and competent care management.

Geriatric care manager **J Donna Sullivan** illustrates culturally sensitive and competent practice through two provocative case studies from her own practice. She demonstrates how GLBT clients are indeed "hidden clients," and the importance of examining our assumptions for all our clients. She reminds us that each case must be individualized to meet the needs of that specific client and that we should not categorize clients with a perfunctory checklist of needs.

Nancy Webster and **Travis Erickson** provide us with an exploration of "place identity," ritual, and oppression for GLBT elders. They demonstrate how the lack of both socially sanctioned rituals and a "sense of place" profoundly impact a GLBT elder's identity. We are challenged to confront our own prejudices and to work toward a society which gives all its members complete access to all the rights of belonging, association, expression, respect, and the ability to age in safety and fullness.

Tarynn Witten closes this special issue with a discussion of the specific

geriatric care issues for the transgender and inter-sex populations. She opens her article with a comprehensive review of quality of life issues for older transsexual and transgender individuals, including access to appropriate medical care and social adjustment to gender variance. Suggestions for sensitive, respectful, and informed practice by geriatric care managers and other helping professionals working with this population are outlined with particular attention given to the issues of body image, sexuality and intimacy, and assisted living and social support.

In summary, this set of five articles complement one another by emphasizing different aspects of the multifaceted challenge of providing quality care to GLBT elders. They provide readers with important information of the unique life situations and needs of this population and offer guidelines for respectful and appropriate care management. I invite you to read and learn from these authors, just as I have, and to include this in your library of resources related to culturally competent practice.

Sandra S. Butler, Ph.D., is an Associate Professor in the School of Social Work at the University of

Maine and is the Faculty Scholar at the University of Maine Center on Aging. She is currently a Hartford Geriatric Social Work Faculty Scholar.

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Long Term Care Issues Affecting Gay, Lesbian, Bisexual and Transgender Elders

By Sean Cahill, Ph.D.

During the past decade the U.S. gay, lesbian, bisexual and transgender (GLBT) rights movement has achieved significant advances. We have seen notable improvements in public opinion toward gay issues, with majority or plurality support for equality in most areas (sexual orientation nondiscrimination, military service, adoption, inheritance rights) except for the right to marry.¹ In 2000, for the first time the National Election Study found that a majority of Republicans support sexual orientation nondiscrimination laws, as do overwhelming majorities of Independents and Democrats (Yang, 2001). There has been a dramatic growth in local and state nondiscrimination laws, such that today more than 100 million Americans—more than a third of the population—live in a municipality or state with a sexual orientation nondiscrimination law. Twenty-three million Americans, or 8 percent of the population, live in a city or state with a transgender nondiscrimination law. Increasingly corporate America is adopting sexual orientation nondiscrimination policies and offering domestic partner benefits to same-sex partners of employees.

The 1990s also witnessed the emergence of a sizable gay voting bloc of four to five percent in national elections. These numbers are all evidence of a growing trend toward equality and political power. Yet GLBT community is just beginning to articulate perspectives in a wide range

of policy debates that affect gay people. While it is obvious that nondiscrimination laws and hate crimes are of particular concern to gay people, other policy frameworks not usually thought of as “gay issues” (including welfare, immigration, and aging policies) can have dramatic and specific impacts on GLBT people.

The Particular Barriers Gay Seniors Face

The GLBT elderly population, currently estimated at one to three million people, will increase to four to six million by 2030 (Cahill, South and Spade, 2000)². We can only estimate the population’s size because most research does not ask about sexual orientation or gender identity. Gerontologists and government researchers could capture much-needed information on gay seniors by adding a standard sexual orientation self-identifier to all surveys, such as the federal Elder Abuse and Neglect Survey.

GLBT elders face a number of particular concerns as they age. Often gay seniors do not access adequate health care, affordable housing, and other social services that they need, due to institutionalized heterosexism.³ Existing regulations and proposed policy changes in programs like Social Security or Medicare, which impact millions of GLBT elders, are discussed without a gay perspective engaging the debate. The GLBT community, led by elderly GLBT activists and elder

advocates, are attempting to change this dynamic, and intervene in these critical policy discussions on behalf of GLBT elders.

Although gay elders share many of the same human needs and concerns as their heterosexual peers, gay and lesbian seniors often experience particular barriers as well. These include discrimination; unequal treatment under Social Security, pensions and 401(k)s; and concerns related to housing, health care, and long term care. Federal programs designed to assist elderly Americans can be ineffective or even irrelevant for GLBT elders. Several studies of both nursing home administrators and directors of Area Agencies on Aging document widespread homophobia among those entrusted with the care of America’s seniors (Fairchild, Carrino, & Ramirez, 1996). Even senior centers can be hostile places for gay elders.⁴ Many GLBT elders do not avail themselves of services other seniors thrive on. Some retreat back into the closet, reinforcing isolation. But GLBT baby boomers who have been out for most of their lives are increasingly unwilling to retreat to the closet when they encounter homophobia in aging services.

Long Term Care Issues

Heterosexism and homophobia are widespread in nursing homes and are symptomatic of a larger sex-phobia often associated with those providing services to seniors. In a mid-90s

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Although gay elders share many of the same human needs and concerns as their heterosexual peers, gay and lesbian seniors often experience particular barriers as well, including: discrimination; unequal treatment under Social Security, pensions and 401(k)s; and concerns related to housing, health care, and long-term care. Federal programs designed to assist elderly Americans can be ineffective or even irrelevant.

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survey of nursing home social workers, more than half said their coworkers were intolerant or condemning of homosexuality among residents, while most other respondents avoided answering the question. The staff in one nursing home refused to bathe a resident because they did not want to touch “the lesbian,” and a home care assistant threatened to “out” a gay client if he reported her negligent care (Cook-Daniels, 1997).

Many gay elders experience actual abuse from care providers. Few service providers have instituted policies to address this homophobic behavior, leaving some GLBT elders in hostile and dangerous environments. In one instance, a nursing assistant entered a room in a nursing facility without knocking and saw two elderly male residents engaging in oral sex. The two were separated immediately after the assistant notified her supervisor. Within a day, one man was transferred to a psychiatric ward and placed in four-point restraints. A community health board held that the transfer was a warranted response to “deviant behavior.” This episode, reported in a 1995 article in *Contemporary Long Term Care*, would not surprise anyone familiar with the experiences of GLBT elders. In a society that desexualizes older people in general, the compounding influence of homophobia can foster a hostile environment for these seniors (Parsons, 1995).

Gay elders entering assisted living facilities and other institutions are often presumed to be heterosexual and may feel compelled to hide their sexual identity. Long term relationships may be devalued and unrecognized. Assisted living centers, congregate housing, and home health care services need to take proactive steps to minimize discrimination, abuse, and neglect directed at GLBT elders. Caregivers should be trained to be competent in issues of sexuality and gender variance. Diversity training is critical given documented examples of bias among senior care providers. Nursing homes should include detailed sexuality policies within residents’ rights policies, and accommodate the appropriate, private

expression of the sexual needs of residents, be they homosexual, bisexual, or heterosexual. Nursing home staff should also be trained to understand and better serve the needs of GLBT clients.

Particular Caregiving Needs

Gay elders may also have particular caregiving needs. Since most caregiving in the US is provided by biological children, and since gays and lesbians are less likely to have children and appear more likely to live alone in old age than heterosexual elders, an urgent question presents itself: who will care for GLBT elders? A number of the problems faced by GLBT elders also stem from the fact that they often do not have the same family support systems as heterosexual people, compounded by the failure of the state to recognize their same-sex families. Since a disproportionate share of GLBT elders live alone, innovative support networks are critical (Brookdale Center on Aging, 1999)⁵. Not only are gay and lesbian elders less likely to have children than the general elder population; they also may be estranged from their families of origin due to homophobia and/or fear of rejection. Consequently, they may not be able to rely upon traditional caregiving support networks.

There are also indications those GLBT elders, who are perceived to be “single” and without attachments (even though they may have life partners and even children and grandchildren), are disproportionately relied upon by heterosexual siblings to take care of parents, aunts, uncles, and other aging family members. Despite the attempts of the right wing to construct “family” and “gay” as mutually exclusive categories, one in three gay men and lesbians provide some kind of caregiving assistance—either to children or to adults with an illness or disability (Fredriksen, 1999). The National Gay and Lesbian Task Force is currently partnering with Pride Senior Network and several Fordham University gerontologists to examine the particular caregiving practices and needs of GLBT elders.

Unequal Treatment Under Retirement

Income Support Programs

In a free-market system, income is a critical determinant in the quality of life one enjoys in retirement, including quality of care for those elders in need of caregiving. Those serving GLBT elders need to take into account the impact of the unequal treatment same-sex couples experience under policies regulating retirement income. For example:

- ♦ Social Security pays survivor benefits to widows and widowers, but not to the surviving same-sex life partner of someone who dies. This may cost GLBT elders \$124 million a year in unaccessed benefits (Cahill et al., 2000).
- ♦ Married spouses are eligible for Social Security spousal benefits, which can allow them to earn half their spouse’s Social Security benefit if it is larger than their own Social Security benefit. Unmarried partners in life-long relationships are not eligible for spousal benefits. We do not know how many millions of dollars a year this costs GLBT elders.
- ♦ Medicaid regulations protect the assets and homes of married spouses when the other spouse enters a nursing home or long-term care facility while no such protections are offered to same-sex partners.
- ♦ Tax laws and other regulations of 401(k)s and pensions discriminate against same-sex partners, costing the surviving partner in a same-sex relationship tens of thousands of dollars a year, and possibly more than one million dollars during the course of a lifetime.

Each of these issues is explored further below.

Social Security

Nearly two-thirds of U.S. retirees rely on Social Security for more than half of their annual income; for 15 percent of seniors, Social Security is their only source of income (Liu, 1999). But lesbians and gay men in

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same-sex partnerships are not eligible for the spousal benefit or the survivor benefit. This lack of eligibility costs lesbian and gay elders hundreds of millions of dollars in unaccessed income per year. The September 11th terrorist attacks illustrated the unfairness of this policy, as same-sex survivors of victims were denied Social Security survivor benefits as well as funds from the victims compensation fund administered by the U.S. Justice Department.

Social Security survivor benefits allow widows, widowers and dependent children to put food on the table, and provide a sense of fairness when an employee pays into the system his or her whole life, but dies before being able to enjoy these retirement savings. But gay and lesbian survivors are not eligible for these benefits. In 1998, 781,000 widows and widowers received an average of \$442 a month in survivor benefits, a total of \$4.1 billion dollars that year. If only three percent of the total population of seniors who survived their life partner are gay or lesbian, the failure to pay survivor benefits costs gay and lesbian seniors about \$124 million a year.

The spousal benefit allows husbands and wives to receive an amount equal to 50 percent of their spouse's monthly Social Security check, if that amount is higher than what their own earnings would make them eligible for each month. In marriages where one spouse earns significantly more than the other and/or has a longer work history, taking the spousal benefit instead of the individual's own payment makes sense. However, lesbian and gay people in same-sex relationships are not eligible for the spousal benefit.

Unequal treatment under pension regulations

Because GLBT people can still be discriminated against in employment in most of the country, and because gay couples are not treated equally under Social Security, pension income is an important policy issue affecting GLBT elders. Social science research indicates that, contrary to a widely held stereotype of gay affluence, gay men and lesbians earn no more than heterosexual men and women. In fact, gay men earn about 15 to 20 percent

less than heterosexual men. Lesbians earn the same as heterosexual women, but because women on average earn less than men, lesbian couple households earn significantly less than heterosexual couple households (Klawitter & Flatt, 1998). Many transgender people suffer from significant economic hardship.

Same-sex spouses do not receive the legal protections provided married spouses under the Retirement Equality Act (REA) of 1984. The retirement income gay seniors lose due to unequal treatment can amount to tens of thousands of dollars a year per individual, and can exceed a million dollars over the course of a lifetime. The design and administration of pension plans vary greatly from employer to employer. Unfortunately, for same-sex couples in retirement, the one aspect most plans have in common is that very few pay benefits to anyone but a legal spouse following the death of a participant. In addition, if a person dies after becoming vested in a pension plan but before reaching the age of retirement, a legal spouse is entitled to a cash benefit beginning in the year that the deceased would have started receiving the pension. The surviving spouse receives this benefit until death. Surviving same-sex partners are not eligible for this benefit.

A hypothetical scenario illustrates the cost of this unequal treatment. Picture two couples, first a legally married heterosexual couple and then a same-sex couple. Everything is the same about these two couples except that the heterosexual couple has the legal protections of marriage. In each couple one partner works for an employer that offers a pension plan. This employee is fully vested in the pension plan, and is entitled at retirement to a sum equal to \$35,000 a year. At his retirement party the employee dies of a heart attack. What does the surviving spouse receive in pension benefits? The surviving spouse in the heterosexual couple would receive \$35,000 (or a portion of this amount depending on the nature of the plan) each year for life. The surviving partner in the same-sex couple would receive nothing. If the surviving heterosexual spouse and the surviving homosexual partner were to die at 75, ten years after retirement,

this means that the surviving spouse in the heterosexual married couple would receive \$350,000 more in retirement income than the surviving partner of the same-sex couple.

Unequal Treatment Under 401(k) Regulations

If a person with a 401(k) plan dies the tax implications for the beneficiary depend on whether or not the beneficiary is a legal spouse. If the beneficiary is a legally married spouse then he or she may roll over the total amount of the distribution into an individual retirement account (IRA) with no tax implications except applicable estate taxes. The spouse can maintain the funds in an IRA until he or she turns 70 and a half, the age at which withdrawals from retirement accounts become mandatory. However, if the beneficiary is a same-sex partner who is unable to legally marry, then he or she is subject to a 20 percent federal withholding tax. Depending on the beneficiary's tax bracket, he or she may also be responsible for paying additional income tax on the amount received, as well as applicable estate taxes.

The effect of this unequal treatment is striking. Assume Deborah dies at age 50 with \$100,000 in her 401(k) account, which she leaves to her life partner, Pat, also age 50. Pat will receive the sum less taxes (at least \$20,000), for a total of \$80,000 or less. Pat is not able to roll the sum over into a tax-free IRA. If Pat were a man and Deborah's widower, Pat would receive the full \$100,000 and be able to shield it from taxes until age 70 and a half. The survivor of the legally married couple would have a nest egg to invest which is at least 20 percent larger than that of the surviving partner in the same-sex couple. The nest egg could grow in a tax-deferred account until the maximum age of disbursement for the surviving spouse in a legally married couple. The surviving partner of the same-sex couple, however, would not be able to roll the initial disbursement into an IRA. Over 20 years time, this unequal treatment could add up to cost the surviving lesbian partner tens of thousands of dollars in potential retirement income.

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Assume Deborah dies at age 50 with \$100,000 in her 401(k) account, which she leaves to her life partner, Pat, also age 50. Pat will receive the sum less taxes (at least \$20,000), for a total of \$80,000 or less. Pat is not able to roll the sum over into a tax-free IRA. If Pat were a man and Deborah's widower, Pat would receive the full \$100,000 and be able to shield it from taxes until age 70 1/2.

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The Medicaid Spend-Down Provision and Same-Sex Couples

Similar to many heterosexual elders, the lack of coverage for long-term care for most GLBT elders constitutes a crisis in their care as well as personal finances. Often seniors who enter nursing homes spend all of their assets on their care and then simply apply for Medicaid when they have next to nothing left, a phenomenon known as the "Medicaid spend-down." Medicaid regulations allow one member of a married heterosexual couple to remain in the couple's home for the rest of his or her life without jeopardizing his or her spouse's right to Medicaid coverage. Upon the survivor's death, the state may then take the home to recoup the costs of terminal care. However, since same-sex couples cannot marry, Medicaid regulations do not offer the same protection for same-sex partners, even if they have spent their entire adult lives together. This unequal treatment can force same-sex couples into a Hobson's choice between getting the medical coverage to meet a partner's health care needs or foregoing medical care in order to avoid giving up the couple's home and life savings. Medicaid regulations should be changed to treat same-sex couples equally to married heterosexual couples. Same-sex partners should be able to remain in their home without jeopardizing their partners' right to Medicaid coverage (Dean, Meyer, Robinson, Sell, Sember, Silenzio, et al., 2000).

Clearly, unequal treatment of same-sex couples under Social Security and retirement plan regulations denies gay elders access to funds we are entitled to, from systems we all pay into all our lives, but which we cannot access due to the

heterosexism of current policies. These unaccessed income sources could help ensure our economic security in old age. Unequal treatment under the Medicaid spend-down provision also limits our economic and emotional security in old age.

Senior Housing Issues

Under the Clinton Administration the Department of Housing and Urban Development (HUD) practice was to make decisions about renting the country's three million subsidized senior apartments without regard to the sexual orientation of applicants. This administrative practice lacked the legal force of a written regulation or federal nondiscrimination law. Inclusion of sexual orientation and gender identity in the Fair Housing Act of 1968 would ban anti-GLBT discrimination in senior housing. Inclusion of sexual orientation in the targeting provisions of the Act, along with outreach training for the staff of subsidized senior housing developments and other congregate housing facilities, would help ensure more comprehensive fairness in housing.

There are now several gay senior housing projects in various stages of development in Seattle, Washington; Boston, Massachusetts; and Palmetto and Fort Meyers, Florida. While gay housing developments are welcome, most units will only be accessible to upper-income people. The housing needs of rural, poor and middle-income GLBT elders can best be addressed by making senior housing gay-friendly and passing a federal nondiscrimination law which covers housing as well as employment.

Health Care

In addition to the need for accessible health care and prescription drug coverage that gay elders share

with other seniors, GLBT seniors may experience physician bias and often lack access to health coverage from a partner's work benefits. Anti-gay bias in health care is widespread. A 1994 study by the Gay & Lesbian Medical Association found that two-thirds of doctors and medical students reported knowing of biased caregiving by medical professionals, half reported witnessing it, and nearly 90 percent reported hearing disparaging remarks about gay, lesbian, or bisexual patients (Schatz and O'Hanlan, 1994).

Assuming GLBT seniors can find appropriate care, they must then face the problem of paying for it. For many, Medicare plays a vital role in covering medical expenses and is especially vital for GLBT old people, as life-long incomes may be lower than similar heterosexual-headed households. One shortcoming of Medicare is that it does not pay for prescription medications. This is especially harmful for the larger proportion of older gay and bisexual men who are living with HIV/AIDS and who need expensive antiretroviral medications. While married spouses often take employer-provided health coverage for granted, most private and public sector employers do not provide such coverage to same-sex partners. These two factors—health care provider bias and lack of access to a partner's benefits—mean many gay people may enter retirement without having accessed health care on a regular basis during their lives.

Conclusion

The documented persistence of homophobia in long-term care environments and senior centers presents barriers to care for GLBT elders and challenges for elder service providers. Elder service and health care professionals can address these

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barriers by mandating training in the particular issues affecting GLBT elders for all those entrusted with their care. Longer term, professional development institutions such as schools of social work, health professional training programs, and gerontology programs can incorporate competency in serving GLBT populations into their educational programs. More research is needed to understand the particular caregiving needs and practices of GLBT elders, who are less likely to have children than heterosexual elders, but who may be relied upon disproportionately to provide care for an ailing parent or uncle. Unequal treatment of same-sex couples under income support programs should be addressed in the political arena. The Democratic National Committee took an important step in this direction by issuing a resolution supporting equal treatment of lesbian and gay couples under Social Security in January 2002. Such a move also enjoys widespread support among the U.S. public.⁶ Finally housing and health policy frameworks also have impacts on caregiving issues affecting gay seniors.

The principle of equal treatment regardless of sexual orientation already enjoys widespread support among the US public. As America ages and a sizable cohort of gay baby boomers enters retirement, GLBT activists look forward to working with elder service professionals and elder activists to ensure that this principle of equality is realized for elder Americans as well.

Sean Cahill, Ph.D., is the Director of the Policy Institute of the National Gay and Lesbian Task Force.

Endnotes

1. A March 31, 2002 ABC News poll found for the first time that more Americans support gay adoption than oppose it, 47 percent to 42 percent. Only about one third to two fifths of Americans express support for same-sex marriage in opinion polls. Most polls about nondiscrimination laws ask about sexual orientation but not gender identity.

2. This figure is based on an estimate that the gay, lesbian and bisexual

population represents 3 to 8 percent of the U.S. population, based on a range of estimates from several studies (Cahill, South and Spade, 2000).

3. Heterosexism is the system that denies, denigrates and stigmatizes any non-heterosexual form of behavior, identity, relationship or community while homophobia is the fear or hatred of GLBT people based solely on their sexual orientation.

4. Forty-six percent of New York state's Area Agencies on Aging (AAAs) the regional entities that distribute federal funds for senior services reported that openly gay and lesbian seniors would not be welcome at senior centers in their areas, according to a 1994 study. And only 19 percent of the lesbian and gay seniors interviewed had any involvement with their local senior center (LGAIN, 1994).

5. The Brookdale Center study found that 65% of 253 lesbian and gay seniors surveyed in New York City reported living alone, nearly twice the rate of seniors as a whole in New York City (36% of whom report living alone). Other studies have found that anywhere from 41% to 75% of older gays and lesbians live alone.

6. In a 1997 Princeton Survey Research Associates poll, 57 percent of Americans surveyed supported "equal rights for gays in terms of social security benefits for gay spouses" (Yang, 1999).

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Culturally Competent Practice with Elderly Lesbians

By Tara C. Healy, MSW, Ph.D.

Although approximately eight to ten percent of the population is gay or lesbian (Cahill, South, & Spade, 2000) there is scarcely any attention given to this population in the gerontological literature. For example, it is common for gerontological and case management text books to devote no more than two pages to elderly gays and lesbians (e.g., Rothman & Simon, 1998). In contrast, there is a large body of literature focusing on long term care in nursing homes even though a far smaller proportion, only approximately four percent, of the population of persons over the age of 65, reside in nursing homes at any given time (Older Americans 2000, 2000). Although approximately the same percentage of the adult population are caregivers as are gay and lesbian, approximately 10 percent, the literature addressing the needs of caregivers is extensive (Feinberg, 1997). This disparity in the literature reflects the heterosexism in society that influences providers of health, social, legal and financial services to lesbians. This article is intended to address this gap in the literature by providing care managers with guidelines that foster respectful practice with the lesbian families they serve. I have drawn the ideas for this article from the literature available, my own practice and a focus group conducted in 2001 with lesbians over the age of 55 years.

Invisibility and Heterosexual Assumption

It may be helpful to begin by defining some terms that are typically used in the lesbian subculture and in the literature concerning lesbian families. Heterosexual assumption means that "parties to any interaction are presumed to be heterosexual unless demonstrated to be otherwise" (Ponse, 1976). "Coming out" or being

"out" refers to self-disclosure that one is self-identified as a lesbian. "Passing" is a term used when the sexual orientation of a lesbian is presumed to be heterosexual.

Care managers must consider the extensive invisibility of lesbian families (Barranti & Cohen, 2000). Heterosexual assumption both facilitates passing and creates barriers to self-disclosure. Therefore, invisibility of lesbian families is, in part, caused by the pervasive heterosexual assumption in society. The process of coming out is an unending process because lesbians typically face heterosexism in every new encounter. Every day lesbians must make decisions about physical, emotional and economic safety related to disclosure of their sexual orientation. The invisibility of lesbian families is further compounded by the existence of "women who have chosen to live their entire lives with other women... and have received the majority of their affection and support from women, yet do not define themselves as lesbian" (Quam & Whitford, 1992). Clearly the prevalence of invisibility of lesbian families calls for a high degree of cultural sensitivity on the part of care managers.

Because invisibility is the norm for elderly lesbians and their families, care managers most likely will not know if an elder is lesbian or has important relationships with lesbians. Moreover, many elders have lesbian, gay or bisexual relatives or friends. Therefore if care managers are to be sensitive to the needs of lesbians, they must practice in a manner that is culturally sensitive and competent regarding lesbian concerns with all families. Conceptually, applying methods that are sensitive to the needs of lesbians with all clients

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Selected Guidelines for Culturally Sensitive and Competent Care Management

- **Awareness**
 - *Begin with self-reflection concerning your views about sexual orientation.*
- **Combat heterosexist assumptions**
 - *Assume that you do not know the sexual orientation of your clients and their family members. Assume that you do not know the gender of significant others.*
 - *Assume that lesbian families have many strengths.*
 - *Assume diversity within the lesbian populations.*
- **Knowledge necessary for culturally competent practice**
 - *Become knowledgeable about how lesbians may be unfairly treated by public policies.*
 - *Be aware of legal protections, such as health proxy or durable power of attorney.*
- **Inclusive language and action necessary for culturally sensitive affirmative practice**
 - *Avoid gendered pronouns when asking about significant others. Ask instead is there anyone who has been a confidant or who has been very important to you.*

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parallels the use of “universal precautions” instituted to protect care providers from exposure to HIV infected blood in the mid-1980s. Initially, many health care providers believed that universal precautions were unnecessary because they thought they could identify gay men and use precautions only with those persons. Soon, however, it became clear that the stereotypes of gay men obscured the reality that gay persons are very diverse in their appearance and thus invisible to care providers. It is proposed that practices that are respectful of lesbian families are respectful to all families and should become part of every day care management practice. It would be unfortunate if care managers replicated past mistakes by assuming they are able to recognize a lesbian or know when to apply specialized techniques.

I will use the phrase “culturally sensitive” to refer to practices that are affirming to lesbian families. Affirming language and behavior validates, acknowledges and accepts lesbian families. “Culturally insensitive” practice consists of negating language and behavior involving denial or rejection of lesbian identity (Healy, 1999). Culturally competent practice with lesbian families requires that care managers acquire knowledge about the diversity within the lesbian population, learn the resources available to lesbian families, gain an understanding of the unique challenges faced by lesbian families due to the laws and policies in force that discriminate against them, and be sensitive to the general impact of heterosexual assumption in the health and social service system.

Struggles with Heterosexism

Cahill, South, and Spade note that lesbian “struggles with heterosexism

can pose serious threats to health, well-being and happiness in old age” (2000, p.17). Heterosexism is institutionalized through laws as well as by the language, behavior, and attitudes of those who serve the public. Lesbians generally assume that they will confront heterosexist assumptions in their contacts with care managers and other health and social service providers. Shevy Healey has described the dilemma posed by the heterosexist assumptions held by

This phenomenon is called “crisis competence” in the literature (e.g., Friend, 1987). However, it is important to realize that there is a great deal of diversity within the lesbian population regarding their views about crisis competence. For example, another focus group member disagreed with the idea that confronting heterosexism strengthens lesbians. She said that the absence of validation for being a lesbian “could have a totally opposite effect” leaving one less prepared for facing the pressure of societal ageism.

Online Resources

Lesbian and Gay Aging Issues Network (LGAIN):
<http://www.asaging.org/lgain/>

Gay and Lesbian Advocates & Defenders (legal matters):
<http://www.glad.org/>

Gay and Lesbian Association of Retired Persons:
<http://www.gaylesbianretiring.org/>

National Center for Lesbian Rights (NCLR):
<http://www.nclrights.org/>

National Gay and Lesbian Task Force Policy Institute, Aging:
<http://www.nglhf.org/>

Download Outing Age
<http://www.nglhf.org/downloads/outingage.pdf>

Old Lesbians Organizing for Change (OLOC):
<http://www.oloc.org/>

Online Information for Old Lesbians:
www.seniorpages.com/gay

Parents, Families and Friends of Lesbians and Gays:
<http://www.pflag.org/>

Pride Senior Network:
<http://www.pridesenior.org/>

Senior Action in a Gay Environment (SAGE):
<http://www.sageofbroward.org/>

care providers: “When I come out I place myself in jeopardy. When I do not come out I feel diminished and fraudulent” (1994, p.114).

Surviving the adversity posed by heterosexism has strengthened some lesbians. One member of the focus group noted that she has become strong because of her experiences in the 1950s and 60s (before the gay liberation movement began). She believes that she is better prepared to face the assaults of ageism in society because of this.

Health and Social Services

Lesbians in the focus group noted that they share the same concerns as other old women: “We want to get good care and be treated well.” For lesbians being treated well means that care providers will not base their communications on heterosexual assumptions. Unfortunately, discrimination against GLBT people is pervasive in the health care system (Schatz & O’Hanlan, 1994). Even well-meaning behavior by providers of health and social services may be received as negating. One lesbian in the focus group described feeling emotionally assaulted every time she has gone for her mammogram because she has been addressed as either

Mrs. or Miss. Both expressions negate her identity because she has shared her life with a lesbian partner for twenty years and is thus not single and is not allowed by law to marry her partner rendering “Mrs.” inappropriate as well. In this situation, a lesbian is forced to “out” herself repeatedly in order not to be devalued. The neutral term “Ms.” does not convey the heterosexual assumption. Moreover, the simple gesture of asking someone how she prefers to be addressed conveys respect and honors an

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individual's wishes. The ongoing process of coming out can be exhausting and anxiety provoking. Lesbians should not have to confront such challenges when in need of health and social services.

Lesbians often experience negating behavior during hospitalization. For example, one lesbian with whom I worked reported that she was unexpectedly hospitalized without a health proxy or durable power of attorney. When she was in a coma, the hospital personnel refused to allow her partner to participate in decision-making. They would talk only to her son. Similarly, one focus group member reported that even when she asked that her partner be listed as her emergency contact at the hospital, someone wrote the name of her sister, who resides in another state, without her permission. Thus even when lesbians face the anxiety that often accompanies disclosing their lesbian identity to health care providers, they may have their wishes ignored. Care managers can play an important advocacy role in such situations by augmenting a lesbian's voice and insisting that her wishes be honored.

Jean Quam provides a vivid example of the negation of a life long lesbian relationship during a medical crisis:

"When a woman in a forty-two year old lesbian relationship becomes disabled, her partner becomes her primary caretaker. However, when the caretaker becomes ill, distant family members take over decision-making responsibilities and without regard to their wishes, separate the women in two different nursing homes. A lesbian social worker realizes the nature of the relationship and advocates with the respective families to have the two women placed together shortly before one partner dies" (Quam, 1997, p. 97).

In this particular situation, a lesbian social worker recognized the importance of this relationship and was able to advocate for their reunion in one of the nursing homes. Lesbians should be able to count on the same respect and advocacy from heterosexual care providers. Recognizing the importance of a life-long relationship

does not mean that care managers should label the relationship as lesbian. Instead, care managers should respect relational significance by considering options for care planning that maintain the continuity of important relationships. If care managers do not expect to see intimate relationships between women, they will not "see" them and therefore not respond in an affirming manner.

Lack of support for lesbian caregivers is another factor that can negatively affect the health and well being of lesbians. Lesbians who are the primary caregiver for their domestic partners do not have access to the same benefits as heterosexual married partners. For example, lesbian partners are typically denied unpaid leave for caregiving under the Family and Medical Leave Act of 1993 (Cahill et al., 2000). Given the double jeopardy of discrimination based on age and sexual orientation in employment, a lesbian takes a great risk to leave her job in order to care for her partner. Care managers must be sensitive to the increased burden that older lesbian couples may face because of possible discrimination and seek alternative means of meeting their care needs.

Financial and Legal Concerns

Care managers must become knowledgeable concerning the financial and legal constraints that face lesbian families if they are to deliver culturally competent services. Economic well-being is intricately related to legal matters involving health care and financial planning. Lesbians in the focus group noted that navigating the health and legal systems can be much more difficult for lesbians who are not out and for those who do not have knowledge concerning their legal vulnerability or the financial means to pay for an attorney. To not have legal documents such as a health proxy or a durable power of attorney leaves lesbians at risk of having their wishes ignored by the health care system. Although laws in each state vary, generally with legal assistance lesbians can obtain legal documents naming their partner, or whomever they wish, as the designated person to make medical deci-

sions should they become incapacitated. Care managers must learn about their state's laws and the resources available to lesbians for obtaining the needed legal protection.

The lesbians in the focus group said that without a will any surviving lesbian or gay partner would be at risk of losing his or her home and his or her economic well-being. Nonetheless, many focus group members noted the limits of legal protection provided by a will. Several noted that even with a will they fear that their partner's family members may contest their partner's last will and testament creating a crisis at a time of acute grief. Given the extreme hardship that may face a surviving lesbian partner, care managers must address these issues as a routine part of care management. Waiting until there is an impending death may be too late.

Financial planning for surviving the death of a partner is very challenging for lesbians. Lesbians tend to be economically disadvantaged due to the lower wages women receive for their work over a life time. This disadvantage has a cumulative effect and is compounded by laws and policies governing health and social benefits in our society (Cahill et al., 2000). Retirement income may be reduced because many lesbians have taken time out of the work force to raise children but will not be able to access their partner's social security benefits, as do married women. Moreover, pensions and 401(k) plans are subject to heterosexist policies that disadvantage lesbians. For example, married partners have access to life long pensions if their partners predecease them. In contrast, lesbian partners receive nothing (Cahill et al., 2000). Further loss may be experienced because lesbian partners are not allowed to roll over 401(k) plans as are married partners and are thus subject to a 20 percent tax on this inheritance. It is important that care managers be aware of these legal constraints on financial planning in order to provide lesbian families with competent services in long term planning.

Lesbians in the focus group were acutely aware of the financial disadvantage they faced because they could not be included on their

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partner's health insurance. One lesbian was paying \$300.00 per month for health care that a heterosexual married woman would receive at no cost through her partner's insurance. Another member of the group had privately paid for health insurance for over 10 years because she could not be included on her partner's insurance. These costs add up over time and make financial planning for retirement much more challenging for lesbians than for their heterosexual counterparts.

Furthermore, heterosexist assumptions may be made by financial planners and lawyers. One lesbian couple reported that they were once given false information by a heterosexual lawyer with regard to their will. Another focus group member reported that she was once told by an insurance representative that she could not name her partner as beneficiary. She stated:

"I knew better and told him that I knew that I could name any one I wished, not only a blood relative. What about other lesbians and gay men who might not know to stand up for their right to name their partner?"

Protection from spousal impoverishment is only afforded to legally married spouses under Medicaid law (Cahill et al., 2000). If a lesbian couple owns their home, they may have to choose between obtaining the medical care needed and keeping their home. Clearly this is an untenable choice. One colleague was shocked when she discovered this constraint in Medicaid law when working with an old lesbian couple. This shock stimulated advocacy and education of her professional peers. Care managers should realize that many of their professional colleagues might lack basic information concerning the barriers lesbians face in current health care policy. It is important that care managers participate in educating their colleagues as well as actively seeking alternative resources for their clients.

There are only nine states that protect against discrimination due to sexual orientation in public accommodation. Low-income housing through Housing and Urban Development (HUD) does not allow for non-related households. Even though this policy

may be ignored in some areas, allowing lesbian partners to live together, lesbians remain at risk of having the policy enforced and thus may be unlikely to seek such housing (Cahill et al., 2000). Therefore, care managers must be informed about the lack of protection lesbians face regarding their housing choices. The potential influence of these policies on lesbians' quality of life must be evaluated with clients.

Culturally sensitive practice techniques should assist care managers in discerning whether or not their clients lack information about pertinent laws and policies that could dramatically affect their lives. Simply exploring clients' wishes without assuming the gender or legal relationship of the person they may choose as a health proxy or beneficiary can open the door to a discussion that addresses a lesbian's true wishes. Given the diversity within the lesbian community, care managers must not assume that lesbians are knowledgeable about these legal matters and government policies. If women living together for a lifetime have not self-identified as lesbian, or if lesbians have not disclosed their sexual identity, they have not had access to information disseminated in the lesbian community. Moreover, lesbians may lack the financial resources for legal counsel. Therefore, care managers should be aware of resources such as the Gay and Lesbian Advocates and Defenders (GLAD, <http://www.glad.org/>) in order to locate legal assistance for low-income lesbian families.

Social and Emotional Concerns

For many lesbians, their social network of friends and family is extremely important and is one of the greatest strengths of their lesbian community. One focus group member remarked, "Powerful women friends are important wherever we live." Sensitivity to the importance of keeping contact with friends and the fear about being separated from their partners and their community of friends is extremely important. In fact, remaining in touch with their lesbian community may be one of the reasons lesbians resist leaving their own

homes to receive health care. The key factor for care managers to remember is that recognition of the powerful emotional support provided by lesbian friendship networks is central to emotional well being in late life for many lesbians. Thus, care planning must include ways in which lesbian families can maintain community contact without suffering from discrimination.

The self-restraint lesbians typically exercise in predominantly heterosexual environments may be experienced as self-negation (Healy, 1999). Lesbians also often exercise self-restraint while engaged in leisure activities. A fairly universal self-restraint is to refrain from touching affectionately even when heterosexual couples are doing so freely. For example, even though all the heterosexual couples were freely expressing affection while watching a sunset, one lesbian in the focus group noted that she consciously kept herself from touching her partner. Lesbians noted that in some cultures, their physical well-being could be endangered if they did not exercise such restraints. These lesbians stated that limitations on self-expression were central to their aversion to relocating into a primarily heterosexual environment such as assisted living or nursing home.

Although friends are very meaningful to lesbians, it is important for care managers to remember that many older lesbians are single; care managers should not assume that friends will necessarily provide the hands-on care that an unpartnered lesbian may need in old age. In one study, 68% of lesbians over the age of 50 reported that they could not identify someone they would rely on for caregiving should the need arise (Cahill et al., 2000). This issue raises the importance of care managers promoting education and cultural sensitivity training for the formal care providers who will be needed by lesbians in the community as well as in residential settings.

Another major problem that is confronted by lesbians and their families is the experience of invalidated grief. Imagine facing a will being contested or one's house being taken

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away during a period of acute grief. Imagine the dismissal of a life partner as “only a friend.” Imagine not being allowed to make funeral arrangements for a life partner. All these experiences continue to happen to lesbians facing loss. Furthermore, heterosexual family members may have their grief invalidated as well. For example, a former heterosexual client once recounted how she had never shared with anyone her grief about the death of her daughter’s lifelong companion because “no one would understand.” It is not only lesbians who must make decisions about coming out to health care providers. Coming out is an ongoing process for family members as well. Thus culturally sensitive practice concerning lesbian issues must be universally applied in order not to negate the importance of relationships in the lives of care managers’ clients who are lesbian as well as those who have important relationships with lesbians.

Guidelines for Culturally Sensitive and Competent Care Management

By applying the following guidelines, care managers can combat the heterosexual assumptions that create barriers for lesbian families and provide culturally competent and sensitive services that are affirming to the lesbian families they serve.

- **Awareness**
 - ♦ Begin with self-reflection concerning your views about sexual orientation.
- **Combat heterosexist assumptions**
 - ♦ Assume that you do not know the sexual orientation of your clients and their family members. Assume that you do not know the gender of significant others.
 - ♦ Assume that lesbian families have many strengths.
 - ♦ Assume diversity within the lesbian populations.
 - ♦ Do not assume lesbians are comfortable coming out to you.
 - ♦ Do not assume that failure to disclose lesbian identity is associated with mental distress.

- **Knowledge necessary for culturally competent practice**

- ♦ Become knowledgeable about how lesbians may be unfairly treated by public policies.
- ♦ Be aware of legal protections, such as health proxy or durable power of attorney.
- ♦ Be aware that lacking a will, lesbian survivors are in danger of losing their homes.
- ♦ Be aware that lesbians may be underestimating their financial needs in retirement because they may not know about the tax burdens they will face in the future.

- **Inclusive language and action necessary for culturally sensitive affirmative practice**

- ♦ Avoid gendered pronouns when asking about significant others. Ask instead is there anyone who has been a confidant or who has been very important to you.
- ♦ Ask how your clients want to be called.
- ♦ Create culturally sensitive forms: spouse/partner rather than marital status.
- ♦ Explore all important relationships. Do not limit inquiry to “relatives.”
- ♦ Use the phrase “sexual orientation” rather than “sexual preference.”
- ♦ Explore intergenerational resources with the inclusive, gender neutral language.
- ♦ Advocate for pro bono legal services for lesbian couples that cannot afford a lawyer.
- ♦ Expand your resource base and refer to gay affirmative social services.
- ♦ Advocate for staff development regarding gay affirmative practices where needed.

The most important point for care managers to remember is that these guidelines must be applied in their work with all families. The invisibility of lesbian families and the lesbian relatives and friends of elders requires the universal application of sensitive practices that affirm lesbians.

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Notes From the Field: Care Management with GLBT Elderly

By J Donna Sullivan, Ms.Ed, CSW,C-ASWCM

As a geriatric care manager, I have found that I have needed to draw on my own intuition and creativity in working with gay, lesbian, bisexual and transgender (GLBT) elders. I have had to learn from my mistakes. There was nothing in my education that specifically addressed the needs of this population, so I've needed to develop practice wisdom over the years. Perhaps above all I have learned the importance of not assuming heterosexuality.

As care providers we need to be informed and sensitive to the uniqueness of the older GLBT client. We need to approach these individuals with an openness that lets them feel that disclosure will be safe and confidential. We must also meet them on their terms. All indications and information may cause one to believe a particular client is homosexual, however years of being closeted may have conditioned this individual incapable of disclosure to physicians, therapists or social workers no matter how non-judgmental these professionals may be. If clients are not willing to "out" themselves to you, then that must be respected. Sensitive questioning can evolve into a relationship that will be beneficial to the client and also to the care manager. For example, asking about special people in one's life, rather than asking the name of a husband or wife can ease a client's anxiety and identify you as a caring and nonjudgmental individual.

Recent studies throughout the United States and Canada have shown that a significant number of GLBT elderly are living alone. Living alone is one risk factor to needing care, so as geriatric care managers we may find these individuals in our caseloads. How do we provide for them and especially how do we sensitize staff to GLBT elders? As geriatric care managers, we must be the role models; we must not allow discriminatory activities on the part of workers to overtly or covertly undermine the care of that individual.

Differences in culture, religion and economic status often are the cause of clashes between caregiver and client. Add to that the possible hostility of a homophobic caregiver and trouble may occur. Identifying open and accepting health care staff is essential to the health and well being of any client, but perhaps in particular an elder GLBT client.

Over the years, I have perhaps had GLBT elder clients who either chose to remain closeted to me, or I, unwittingly, assumed heterosexuality. My growing awareness of this population became key to better assessing the clients that came seeking services. The following two cases were not only memorable, but were also true learning experiences for me. The client names have been changed to protect their privacy.

Clarence B.

Clarence was a 79-year-old gentleman whose family was out of state, and who wanted to make sure he was taking care of himself after a long hospital stay. I was assigned as his care manager and although he never specifically stated he was gay, he did speak openly to me about his long time companion who had passed away some years before. He understood that he needed someone to help him when he got home and I went about setting things up. One of Clarence's eccentricities was that when he went out he would wear make-up and rather dramatically at that. I, however, didn't take that into account since he did not wear makeup when he was in the apartment. I set him up with a home health aide that I had worked with before and he seemed pleased with the arrangement. Then, one day, I got an hysterical call from the aide babbling about going out for a walk with Clarence and the make-up. I set a time to meet with the aide and listened to her story of shock and disbelief when she and Clarence were venturing out for their first walk together. I had to make a quick assessment of the

situation since I knew that the aide was excellent but just uneducated in GLBT issues. I explained about Clarence and hoped for the best. Although she had strong religious feelings she agreed to continue working for Clarence and as time went on they became quite close. The aide also started buying makeup for Clarence, reporting he was not using the correct color!

Rose K.

In another case that I handled many years ago, I came face to face with my own inability to recognize a GLBT elder. I was also at a loss to know exactly how to handle the situation and had no real resources upon which to draw. The following is my story of Rose.

Rose was an 83-year-old Polish born single woman who had been referred to our office through a guardianship proceeding. Rose had been living alone in a rather fashionable apartment for many years and had been functioning well on her own. She had fallen on the street one day and was brought unconscious to the local hospital. Tests revealed that she had a large tumor behind her right eye but she refused surgery. Hospital authorities felt she was also suffering from dementia and contacted legal services. After a guardian was appointed, our offices were contacted to get her apartment in order and to set up home care. On my initial visit, I found a very cluttered, dirty apartment but with beautiful paintings and sculptures throughout. I arranged for cleaning and garbage removal. I also had a hospital bed brought into her bedroom. In the bedroom was a freestanding metal closet with a chain and lock on it. It was rather small and I merely moved it to the other side of the room in order for the bed to be moved in. Several days before Rose was to come home I had to move the closet again and I thought, "if it was empty maybe it could be discarded." I quickly broke the flimsy lock and

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found contained inside more clothing - men's clothing- but not thinking further of this, I just closed the doors

One of Clarence's eccentricities was that when he went out he would wear make-up and rather dramatically at that. I, however, didn't take that into account since he did not wear makeup when he was in the apartment. I set him up with a home health aide that I had worked with before and he seemed pleased with the arrangement. Then, one day, I got an hysterical call from the aide babbling about going out for a walk with Clarence and the make-up.

and moved it to the hallway. Back in my office, I inquired if Rose had been married and was told no. I kept thinking about the clothes I had seen. The next day I waited in the apartment for Rose to come back from the hospital. The closet still intrigued me and I took another look. I now

surveyed the contents more closely – several men's shirts, a man's suit, ties, two fedora hats, and a pair of wing-tip shoes. What struck me about them was that they all were extremely small, especially the shoes. I took out one of the jackets and held it up. It was much too small for even a small man – then I realized, perhaps these were her clothes? I closed the closet and re-locked it.

Over the next several weeks I saw Rose. She did not like me; I was considered a nuisance. But I found her weak spot – Hagen Daas Vanilla Ice Cream! She slowly softened and began to tell me about her work and her travels through Europe and the world. One day she asked me where the metal closet was and I showed her where I had moved it. She then asked me if I had opened it. I thought a minute and although I could have easily said "no" I told her I had. Initially her response was of anger and then she began crying. In that instant, I thought, "now what am I supposed to do?" Suddenly it came to me and I leaned over to her and said, "Don't worry Rose, I have a closet like that at home myself." With this statement her anger and tears stopped and a moment later she looked at me and smiled.

After that day we spoke openly about her life as a gay woman in the 1930s and 1940s—it was intriguing and wonderful. As her tumor worsened, there were some days she couldn't talk but she knew I would keep her secret. Some weeks later she returned to the hospital and lapsed into a coma, we never spoke again. I had known her 3 months.

Both these cases, though quite different, point out the complexity of the issues we face as we try to best serve our clients. There are several things we can do to enhance the quality of life for our aging GLBT clients. For example, we can use gender-neutral forms, categories that ask for "significant other" rather than spouse. When possible, we should look around the homes of our clients for clues—perhaps there are photos, books or magazines that provide insights about our clients' sexual orientation. I have found that the more information I can garner before setting up home care, the better, so as to avoid the potential problem of

assigning home care staff who are unprepared or unwilling to work with GLBT clients. Soliciting this information from the client or the client's family members should be done with sensitivity to the client's privacy, and may require indirect questioning when clients or family members are particularly protective or ashamed about the client's sexual orientation.

Ultimately, we should not assume a probable lifestyle nor should we categorize clients with a perfunctory checklist of needs. We should do everything we can to ensure an educated and accepting staff. Each case must be individualized to meet the needs of that *specific* client. And in the GLBT community that must be done with understanding and a conscious belief that one is doing the most one can to make one's client feel as comfortable as possible.

Training and education will be the mainstay of any initiative to improve geriatric care. In a recent paper delivered before the Senate Committee on Aging, Perry (2002) emphasizes the need for geriatric training at all levels and warns of the problems that may lie ahead: "Despite decades of warnings from policy makers, physicians, social scientists, and advocates, an acute shortage of health care professionals with geriatric training persists in the United States" (Perry, p. 2). Furthermore, he advises, "students in virtually every health care field—social workers, nurses, pharmacists, and physicians, must receive geriatric training as part of their course work." (Perry, p. 4). Clearly, any geriatric training initiative will be improved if it includes the needs of our GLBT elders. It is my hope that we will all learn and develop new and innovative approaches for this vulnerable and hidden population.

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Rethinking Community, Place and Ritual in Aging GLBT Populations

by Nancy Webster, MPA, MSW, LCSW And Travis Erickson

We sit, curved over computers, in a small office in a corner of the University. We are a young, gay, graduate student and an aging lesbian professor struggling to put order to our thoughts on the aging process. We tease out words and concepts, reality and optimism from the flatness of words. There are muffled sounds outside the office door. We are working late into the evening as a group meets in the classroom across the hall. The campus Gay/Lesbian/Bisexual/Transgendered (GLBT) Group has been guaranteed privacy, secrecy for its furtive monthly meeting. The shades have been drawn. The doors have been closed. Absolute privacy has been extended because of fear of exposure. Fear drives the need for secrecy and privacy on this university campus - fear and the extension of oppression. There are both internalized fears from previous experiences with being homosexual and fear of the physical environment. With the hushed background noise, we continue our task of reaching for words of meaning for this article on GLBT aging. We twist language and hope for eloquent statements to those who help, heal and guide aging gay and lesbian elders. As we finish our night's work and leave the building we reflect on the shadowy shapes moving behind the drawn blinds in the building and once again the issues of safety and identity flash in front of us.

One of us no longer needs to hide her lesbian identity; she is privileged within oppression. She is white, educated, appears more traditional than the internalized image of "a lesbian," but as she ages the issues that have shaped her as a lesbian in the dominant culture increasingly challenge her. As we write, the younger gay co-author speaks of his committed relationship and the fear he

has that if he and his partner were to have children and something should happen to him, his parents, rather than his partner, might gain custody of the children. His are not random musings; his partner is a police officer, a gay male in a bastion of heterosexuality. We murmur softly of oppression and continue on with our writing. He, too, is privileged within oppression; he is white, middle class, educated, and appears more traditional; relatively more "straight" than many gay men. But together, a generation apart, we will move into aging with a shared history. This history includes a lack of "place" in the dominant culture, an absence of ritual and the omnipresent and cumulative stressors of ageism and presumptive heterosexuality.

While both the mainstream culture and GLBT individuals must confront the issue of ageism, gay men and lesbians must also confront heterosexism and institutionalized homophobia as a component of the aging journey. This article examines the integral components of "place identity," ritual, and oppression as part of the identity formation and aging journey of GLBT elders. This paper further examines the triad of ageism, heterosexism and institutional homophobia as markers of the aging journey. Finally, consideration is given to the matter of "presumptive heterosexuality" and homophobia as a harsh force in the aging experience of gay and lesbian individuals.

The issues embedded in the gay and lesbian aging population are both congruent and incongruent with the heterosexual population. Congruent issues include reduced income following retirement, cumulative loss of friends and family members and confrontations with ageism in our culture. The issues that appear incongruent include the linking of ageism and homophobia, the lack of

legal and public recognition of same-sex relationships, the "coming of age" as an elder in a youth-oriented GLBT, and coming out under significant public scrutiny and judgment. The lack of congruence is also illustrated in the lack of a "sense of place." Place, both in the sense of a physical place and in the safety of place. Further lack of congruence includes the lack of socially sanctioned rituals, such as marriage, and the construction of a sense of self and an identity with a life lived in secrecy. It is the life lived as shadowy shapes behind drawn blinds.

Let us first consider the identity and composition of the aging GLBT population. This culture has developed and matured in a social climate with few civil rights, often hidden identities, few socially sanctioned rituals, and little development of place attachment nor identity with a sense of place. Gay and lesbian individuals have often experienced a deep institutionalized and personalized oppression. There have been few public monuments and permanent public spaces dedicated to or in acknowledgment of gay and lesbian identities. The temporary claiming of public space through Gay Pride parades and demonstrations is a strategy that speaks to this lack. Rituals, in the form of coming of age, coming out or of marriage ceremonies, have not been part of the developmental and social construct of the GLBT community. It is ritual that lays the foundation for social and cultural recognition (Laird, 1984). Without a foundation for social and cultural recognition there is a concurrent grief and loss process; a legacy of historical trauma. There is also a searching for and seeking of an identity validated by the culture.

Gay and lesbian individuals experience coming out as a lifelong
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 process. Coming out is defined as being open and visible about one's sexual orientation to oneself and others. The issue of proclaiming a gay or lesbian identity is always complicated. It is complicated for youth and it is particularly complicated for the aging individual who must come out in midlife or in institutionalized settings, such as during hospitalizations, or in the application for social services. However, coming out to health care professionals and social workers is often a necessity for GLBT elders so that they can maintain access to their partners or their community. Aging GLBT individuals have grown old in an environment of persecution, isolation, marginalization and unacceptability. The lack of both "place identity" and the choice of safe and welcoming venues has complicated the coming out ritual. Coming out and claiming to oneself and others one's sexual identity, while always a courageous act, defines the individual and places the individual at the margins of the culture—it identifies the individual by his or her sexual orientation. One's identity quickly becomes linked to sexual orientation rather than to the continuum of traits that makes one whole. One becomes the gay male, the lesbian professor, the gay police officer, and the lesbian farmer. One loses one's wholeness, one's roundedness, and one's centrality to the trait of sexual orientation.

Oppression, as described by Young (1990), consists of five "faces": exploitation, marginalization, powerlessness, cultural imperialism, and violence. Each of the faces represents a family of concepts and conditions that present a "disadvantage and injustice" to a particular group or individual. A group is described as being oppressed if at least one of the five faces impacts the respective group or individual. In most cases oppression is a product of a "well-intentioned society," though manifestation of dominant value and political systems often go unquestioned (Young, 1990). While older GLBT people report high life satisfaction and low self-hatred, a significant number

of those who are "out" still experience high levels of shame, poor health, and loneliness (D'Augelli, Grossman, Hershberger, & O'Connell, 2001). The negative systems of thought brought about by the systematic oppression of gay and lesbian adults may be covertly internalized within the individual resulting in diffused forms of self-hatred and shame. The encasement within the identity status of gay and lesbian and within the physical body, social body of community and the body of culture and locality, all contribute to being moved, placed, and pushed to the

While both the mainstream culture and gay and lesbian individuals must confront the issue of ageism, gay men and lesbians must also confront heterosexism and institutionalized homophobia as a component of the aging journey.

margins of the culture

How do the issues of ritual, place and oppression interact with the aging individual and the dominant culture to shape the aging process? How do we establish a healthy aging identity when there is no distinct culture or sense of shared history to connect gay and lesbian individuals to their environment and culture? Let us first look at the issue of place identity or place attachment. Place attachment

is a positive emotional bond that develops between individuals or groups and their environment (Altman & Low, 1992). In that sense, the study of place attachment is the study of emotional investment in place. Place attachment, that is the connection to safe and welcoming places, link an individual to his or her environment. Place attachment is likely to help individuals to develop a set of norms and effective formal and informal controls over their environment. Neighborhoods, communities, public monuments, and the social and physical nature of the area often mark attachment to place. But what of those who cannot claim a sense of place, what of those who remember place as dangerous, secretive, furtive, and hostile? What of those who remember place less as a positive physical environment and more as of a series of bars, clandestine weekends or week long vacations at GLBT friendly resorts? How is aging impacted when social relationships are non-local and people have no attachment to the physical community?

Along with the deprivation of place identity, individuals in the aging GLBT community have not experienced symbolic rituals. Rituals reveal the deepest levels of shared meanings and values, and rituals link individuals to the self and to the community. Rituals are symbolic and they communicate metaphorically groups' shared constructions of reality. Rituals also legitimize particular worldviews, moral stances or social constructs. Rituals may perpetuate cultural myths and have tradition-making power and shape cultural unity. Rituals, such as baptism, marriage, and anniversaries speak to the non-verbal part of the self, and shape the unspoken in the dominant culture. Such rituals minimize disconnections, differences, paradoxes, and conflicts (Laird, 1984).

In the gay and lesbian population, ritual is often disconnected from tradition making power and from cultural unity. There are no symbolic rituals that indicate a transition, a separation, or an alteration to or from couple status. There

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are no rituals of incorporation, no marking the establishment of new families, no moments of signaling a change in the family's or individual's equilibrium. There are no rituals for aging, retirement, or rituals to ameliorate the sadness precipitated by the relocation to a new home, assisted living center or nursing facility. These rituals for aging and the marking of aging in symbols are also absent from the mainstream culture. However, there is a particular poignancy that is present in the GLBT elder community. This poignancy is particularly painful because identity for GLBT elders is so diffused, so rife with "presumptive heterosexuality", that in order to create rituals for aging one must again "come out" as gay and lesbian and "come out" as old. This process moves the individual to the margins of the culture.

A consideration of the issues of place identity and ritual leads one to question why we, as gay and lesbian people, don't have connection to place or form? Why have we not developed our own mythology, traditions, forms or functions? Such questions spiral back on to the overwhelming effects of living life on the margins - shadowy shapes behind window shades - and the lack of public acknowledgment of GLBT individuals. As we circle ourselves, we are again confronted with the effects of oppression of gay and lesbian people and the potential impingement on the aging process.

And where do we stray as aging gay and lesbian individuals? Does the pressure of prejudice force us to become placeless, displaced, not belonging to a nation, to a class, to a region? Does oppression force and shape our lack of ritual within community, and ultimately how does this encroach on the aging process? If we are to assume that the forces of homophobia shape cultural responses to gay and lesbian individuals, how are we to understand the experience of aging in a youth-oriented gay and lesbian culture? How are we to understand the pressure of coming out in mid-life, and how are we to

understand the aging process with few models for healthy aging?

Can we imagine for a moment the experience of the late life gay male disclosing to his children and grandchildren his "gayness?" Can we imagine the experience of lesbian partners struggling to come out to health care professionals, to nursing home officials, in order to feel safe as lesbian individuals in the multiple systems that comprise old age? Can we reflect on the experience of disconnection from the gay and lesbian community because of age, and disconnection from the heterosexual community because of same sex preference? Can we move in our compassion and understanding of GLBT elders to that place of isolation, fear and loneliness and still understand that these individuals experience high life satisfaction, and high self esteem? Can we, as helping individuals, immerse ourselves in the paradox and can we be a part of reducing the pressures of oppression?

Let us use, for a moment, a theoretical lens in considering identity development and the relationship between identity development and ritual and place. In what way do displacement, and the lack of ritual and the forces of "presumptive heterosexuality" work to shape identity. Anthony D'Augelli (1994) proposed a model of lesbian, gay and bisexual identity development. D'Augelli's focus is on the identity process as a social construction. He offers several assumptions as a foundation for his theory. First, sexual identity is a life long process and may be fluid like with its developmental plasticity. Second, the individual must give up the heterosexual identity that they have possessed since birth. Third, an individual has a significant role in their own development through making choices and taking action. D'Augelli identified three sets of interrelated variables, which interact to mediate the identity development process. The variables are labeled as personal subjectivities and actions, interactive intimacies, and sociohistorical connections. Sociohistorical connections may be

understood as place identity, interactive intimacies as form, symbol and ritual and personal subjectivities as development of identity within the culture.

If we draw on D'Augelli's model for lesbian, gay, and bisexual identity development as a framework for understanding the individual's development within a social context, we can begin to paint a picture of how the individual lesbian or gay elder is impacted. Personal subjectivities connect one's psychological processes, self-concept and the expression of feelings to the external world. Exposure to the scripts for straightness become internalized and learned from the relationships with others and from stimuli throughout the culture in the United States. Interactive intimacies refer to those relationships we have with other people, for instance, sons, daughters, siblings, parents, peers, etc. These relationships are transactional for most as we gain from these relationships, and presumably give in return. However, there are barriers to these transactional relationships for gay and lesbian individuals and often these barriers are formed because of their gay or lesbian identity. Relationships are invaluable to maintaining a sense of self-worth, and significantly contribute to the formation of place attachment. Sociohistorical connections may refer to the laws, policies, local history, and greater cultural systems in which the lesbian or gay individual exists. These systems impact the individual, often with unearned consequences related to the fear, hatred, and invisibility of lesbian, gay and bisexual individuals in the U.S. Consequently, the impact on the individual lesbian or gay elder brings to bear challenges within our relationships. Lesbian or gay elders do not solely feel the impact of these systems. Women and men who identify as straight and become confined by these scripts also feel the impact.

Keeping this model in mind let us return to the shadowy shapes silhouetted behind the drawn blinds.

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Metaphorically, these shadowy shapes are also our gay and lesbian elders and the question may well be, how do we lift the shades to reveal positive methods to support these individuals in the process of "healthy aging?" How do we clear the trail of homophobia and "presumptive heterosexuality" that are so often insidious? Do we take the time to understand how a "presumption" of heterosexual identity may shape and define our perspective on individuals? How do we give a rooted quality to the lives of aging GLBT individuals and how do we assist with form and ritual to allow fullness in the aging process?

We must begin at the beginning. The beginning is the process of breaking down the assumptions that lead to "presumptive heterosexuality" and heterosexism. This will require education, confrontation, systemic intervention, and dialogue with health care providers and individuals who work with and give care to aging GLBT elders. It will require challenges and participation by leaders and educators, and it will require the development of a common language to speak of the issues that affect the health and well being of these gay and lesbian elders. It will also require confrontations with the self about the "presumptive" qualities of our own thinking, about the small prejudices we maintain, and the little innuendos and cruelties we inflict on others because of those prejudices. It will also require a rethinking and reorienting of the wisdom, and value we place on aging and elders and demand that we, as providers of service to these individuals, confront our own ageism, our own internalized homophobia and our own levels of "presumptive heterosexuality."

Second, "place attachment," and ritual must be acknowledged and included in our conversations with the aged, and development of safe physical place to accommodate aging gay and lesbian individuals and their partners must be created. Further, health care professionals must begin to raise their own consciousness

about the issues of displacement and the need for ritual in the aging process.

During the writing of this article a colleague tearfully related to us a story from her recent life. Her close friend of 30 years had recently died of a brain tumor. Her friend was a lesbian and, together with her partner, had raised a son. The son, now in the military, was denied compassionate leave to attend his "other mother's" funeral because they were not of a blood relationship. The remaining family members grieved separately from him, not unified by a ritual of death, displaced by homophobia. This young man will retain this experience forever. His mother's death may well become secondary to the deprivation and harshness of oppression. As individuals serving older adults we have a responsibility to challenge these moments, but the challenge is far better served if we know our own feelings about homosexuality and ageism.

None of us are free of homophobia. Certainly in a culture that oppresses one group, all groups are equally oppressed. Homophobia is no exception, nor is ageism. For those who hide behind the blinds as shadowy shapes, the rest of us remain closed out, deprived, and limited by their experience. For those who deprive life partners of moments of intimacy in nursing home or institutional settings, or choose not to understand the dynamics of oppression, or choose not to join with GLBT elders, they too are deprived of the richness of knowing individuals fully.

It is the challenge and the responsibility of society and culture to enable all its members to grow into their full humanity, with complete access to all rights of belonging, association, expression, respect and the ability to age in safety and fullness. People who are drawn to intimate relationships with people of their own gender are no less qualified, needy, or deserving of those rights. Individuals who have grown old under the heavy burdens of socially accepted contempt, bigotry and fear are among our most powerless

oppressed citizens. We must not cease to correct those attitudes which allow for such inequitable conditions, beginning with our own prejudices and fears. Only when any group of individuals feels free to meet inside lighted rooms, with open shades, can we all be more free.

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Geriatric Care and Management Issues for the Transgender and Intersex Populations

by Tarynn M. Witten, M.S., Ph.D., FGSA

Background

The historical development of modern day biomedicine, psychology, and psychoanalysis is bound up in the complex interactions of a Eurocentric, heterosexual, Judeo-Christian viewpoint. Obviously, restriction of the underlying theoretical construct of sex and gender to the dualistic genital sex model has eliminated all biomedical and psychosocial health care research on behalf of both the intersex population (Witten, 2002) and gender-variant individuals (South, 2000).

Clearly, limiting the discussion to dualistic heterosexuality forces health care workers to buy into the Judeo-Christian paradigm of the family. This consequently eliminates all theoretical constructs that would deal with non-normative sexualities, genders, and the potential variety of combinations that emerge from partnering and creation of families (both immediate and extended). For example, such a restriction could not realistically attempt to address issues of elder care for transgendered elders within the family or in any type of retirement, assisted living, or nursing home facility. Assumption of heterosexuality also eliminates any theoretical constructs dealing with the dynamics of aging for non-normative sex and gender roles in a heterosexual society (See for example: Currah & Minter, 2000; Grant, 2001; Grossman, D'Augelli & Hershberger, 2000). Given the extensive body of literature detailing the importance of social support networks, religiosity and spirituality, and quality of life issues in the "normative" elderly heterosexual population, it would not be a surprise to health care workers that these areas need to be addressed in the elderly gender-variant and intersex communities as well.

Defining Gender-Variance, Transgender, Transsexual and Intersex

It is impossible, within the brief space available here to address all of the different variants for definitions of

transsexual, transgender and intersex. For definitions related to gender-variance, the interested reader should review Witten and Eyler (1999) and the references contained therein. Gender minority persons (also referred to collectively as the "gender community," T* community, or transpersons) include transsexuals, transgenders, cross-dressers, and others with gender self-perceptions other than the traditional Western dichotomous gender world-view (i.e., including only male and female). The descriptors used by transpersons are varied and dynamic. I will use these general labels as a first approximation for discussion. For a detailed discussion of the intersex condition and intersex definitions, the reader is invited to read the literature at the website of the Intersex Society of North America (www.isna.org) for further details.

Cohort Effects

Based upon preliminary data regarding incidence and prevalence in the United States and worldwide populations, I have made estimates (Witten, 2002) of the projected numbers of elder transgender and intersex persons in the United States and worldwide. Using these projections, I have been able to demonstrate that there will be an increasing number of elder members of both the intersex and the transgender communities over the next decades. It is also vital to understand that both the intersex and the transgender elder populations contain a number of sub-populations with unique lifecourse experiences.

Looking at these two general populations, we can see that the elders of the intersex population will be likely comprised of a number of smaller cohort populations. Most of the elder individuals will likely have had genital surgery forced upon them at early ages and may have been subjected to hormonal treatments as well. Consequently, they may well be dealing with numerous psychological issues related to the undesired violation of their bodies and the effects that the undesired surgery has had on their lifecourse. Additionally, if

they have had hormonal treatments for any length of time, they may well be dealing with the medical consequences of long-term hormonal usage dating back to a period of time when hormone doses were much stronger than those currently used.

For the transgender or transsexual population, as well as the younger old (i.e., 60 to 74 years of age) intersex population, individuals will fall into various sub-cohorts; themselves further sub-divided based upon numerous factors. For example, for a given younger old transperson, time of transition (hormonal and surgical modification) can be important to understanding the aging process. There are many ways to arrive at the endpoint of being an older transperson. A person may be elderly when they choose to transition or they may already have transitioned earlier in life and now are older in their contra-gender identity and body, having dealt with a longer duration of lifespan in the already transitioned state. Thus, one individual is old, but has lived only a short period of time within the contragender roles, while another is old; having lived a long time within the contragender roles. Each of these individuals may or may not be hormonally or surgically modified. And, as such, their lifecourse experience as elders will be different and require understanding from the geriatric case manager and caregiver. Currently, Female-to-Male (FTM) transsexuals usually self-identify during their teens, twenties, or thirties, often following a period of years of lesbian identification. However, male-to-female (MTF) transsexuals and transgenders more often attempt to suppress their self-perception of gender variance for years or decades, and therefore frequently present for medical sex reassignment services during mid-life or older age.

Transsexualism and Other Gender Identities

Transsexuals experience variance (not deviance) between natal sex and "psychological" gender and often

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seek medical sex reassignment services, including hormonal therapy and genital surgery. Transgenders frequently identify with, or are ambivalent about, the “natal” genital sex and often adopt a lifestyle and appearance that is consistent with their psychological gender self-perception. This is often supported by the use of hormonal medications, but genital sex reassignment surgery is usually not desired (although it may be eventually considered and pursued). Some transgendered persons present as members of their natal sex in certain situations and for practical reasons, such as to avoid premature termination of employment. Cross-dressers cultivate the appearance of the other sex, particularly with regard to clothing. Cross-dressing may be undertaken on a part-time or recreational basis, such as at clubs and social events, and may or may not have erotic significance. Women who prefer men’s clothing because of its comfortable or practical nature, but who self-identify as female, are not considered to be cross-dressers.

Many indigenous peoples also recognize genders other than male and female. For example, Tewa adults identify as women, men, and ‘kwido’, although their New Mexico birth records recognize only females and males. Persons with such non-Western gender identities are also gender minority individuals, although discussion of the cultural and anthropological aspects of gender variance is beyond the scope of this paper. It is also difficult to provide data-based information about some of the health issues faced by elderly transsexuals, as this group is particularly “epidemiologically invisible” (Witten, 2002), with many of its members preferring not to reveal their natal sex due to perceived and real risks and stigma associated with being “out.” In contrast, most “out” (i.e., publicly identified) transsexual, transgendered or cross-dressing persons are young adults; many have chosen to be involved in political activism on behalf of the gender community. Nonetheless, in an era in which forecasting the health of elderly populations is increasingly more important, discussion of quality of life issues faced by older transsexuals and other gender minority persons should not be further deferred. For an excellent general overview of aging issues in the LGBT community, see South (2000). Issues of health for the LGBT are extensively discussed in the *Healthy People 2010* (2000) and the companion document to the Healthy People 2010 (GLMA, 2000).

Finding a Place: Quality of Life Issues for Older Transsexuals

Contragender medical care.

Individuals who pursue gender transition later in life face different challenges than do their younger peers, and also possess certain advantages. Quality of life issues may be affected by a constellation of medical and social considerations. These issues are both similar and dissimilar to those encountered by non-transsexual elderly persons. In this section, I will briefly explore the realities influencing quality of life for older transsexual, transgendered, and cross-dressing individuals.

Two types of individual will be considered. The first is the older trans-individual who transitioned earlier in life and has experienced a significant portion of the adult lifespan as a contra-gendered individual. Here, questions relating to long term stress (Kraaij, Arensman, & Spinhoven, 2002), negative life experience, long-term exposure to hormones, and transition in midlife can profoundly affect socio-economic status for the transperson. While this can have numerous immediate effects, it also has long-term effects. For instance, alterations of the oral environment—saliva production for example—due to use of estrogen could have potential implications for long-term risk of cardiovascular disease.

Persons who undertake gender transition during mid-life or the elder years are more likely than their younger peers to experience difficulties related to physical health status. Ill health, especially cardiac or pulmonary dysfunction (Aronow, Ahn, & Gutstein, 2002), may preclude eligibility for surgical procedures including breast or genital reconstruction. In addition, persons with moderate or severe hypertension or other conditions of old-age may be poor candidates for estrogen therapy. Similarly, androgen supplementation in female-to-male (FTM) transsexuals and transgendered persons may exacerbate depressed HDL cholesterol and increase coronary artery disease risk. Androgen supplementation is also a risk factor for the development of polycythemia, a potentially life-threatening condition, but may benefit FTM individuals with pre-existing anemia or loss of bone mineralization. While much is known about pharmacology of aging and about hormones and aging, little is known about the interaction of “normal” aging processes and cross-hormonal treatment, from a physiological,

psychological, and biomedical perspective. One exception is the work done by Asscherman, Gooren, & Eklund (1989) on the mortality and morbidity rates for transsexual and transgender patients on cross-hormonal treatment.

Health care and personal assistance services are more complex for persons who are transgendered than for those who are transsexual and post-operative. Apparent mismatch between genital anatomy and gender of presentation can result in difficulty in obtaining medical services, practical nursing care, or even appropriate funereal arrangements (as in the case of Billy Tipton, whose female genitalia were “discovered” by the mortician and sensationalized in the tabloid press). More recently, Tyra Hunter, a pre-operative male-to-female transsexual was refused appropriate and timely medical care by Washington, D.C. paramedics who, when arriving on the scene of a hit-and-run car accident involving Ms. Hunter, discovered her transgenderism. Believing that her gender incongruity implied that she must also be homosexual, the paramedics refused to render treatment because they thought that Ms. Hunter might have AIDS. The case of Leslie Feinberg, who was forced to leave an emergency room when his female anatomy was discovered, is also well-known in the gender community. Many health care personnel consider transgenderism (or transsexualism or cross-dressing) to be evidence of psychiatric pathology, and inappropriate psychiatric referrals may result.

The financial aspects of transsexual and transgender healthcare are also affected by gender discrimination. Many FTM transsexual and transgender adults begin gender transition after years of lesbian identification. Survey data (Eyler and Witten, unpublished) indicate that incomes well below the national average are commonplace. Conversely, MTF transsexual and transgendered persons tend to be older at the time of transition, and to have enjoyed decades of male privilege and income. Nonetheless, attempts to transition in the workplace are at times met with dismissal; only one state and a handful of municipalities provide legal protection from employment discrimination based on gender presentation.

Despite the increased medical risks that may accompany gender transition for older persons, the physical (morphological) realities of aging may facilitate social gender transition. For example, women and

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men share more physical similarity during the elder years than at any time since childhood. Loss of facial skin tone produces a softer appearance for many genetic males, and the natural diminishment of circulating estrogens, accompanied by a shift towards andronization of the hair follicles, facilitates the production of new beard growth in FTM transsexuals. Furthermore, the loss of muscle mass and increased body fat content which is experienced by both male and female elders often results in phenotypic gender convergence of the body habitus (i.e., women and men appear more alike than previously with regard to body fat distribution, girth and posture). These physiologic alterations are clearly advantageous to transsexual persons who begin the transition process later in life, as they may obviate the need for excessive weight reduction (for genetic males), body building muscle development (for genetic females) and minor cosmetic procedures (for both).

Physical functioning, such as that required for the performance of the usual activities of daily living, is generally unaffected by gender transition or sex reassignment surgery, as far as we currently know. Progression to ADL dependence in the transgender population is unstudied and important. Exceptions include cases in which post-surgical recovery is complicated or prolonged, or in which empathic, non-judgmental personal care assistants are unavailable during the post-operative period.

Although cross-dressers do not usually seek contragender hormonal services, middle-aged and elderly cross-dressing persons often experience difficulty in obtaining appropriate healthcare services due to privacy concerns. For example, most MTF cross-dressers remove leg and body hair in order to appear as normal women while dressed *en femme*. The need to seek medical care often forces the dilemma of whether to disclose one's personal behavior to the physician or other practitioner, or whether instead to attempt to postpone services until the body hair has re-grown. In those cases in which a chronic illness is present, avoidance of medical care for any length of time can have serious consequences. Situations in which the cross-dressing individual requires emergency (cardiac, for example) or long-term care (nursing home, rehabilitative care, for example) can be problematic for similar reasons.

Gender variance and social adjustment. Quality of life issues for older members of the gender commu-

nity often center upon the degree of social integration which the individual has been able to achieve earlier in life, or on the personal flexibility and resilience available for the development of new relationships during the later years. Community resources and acceptance of persons with non-traditional life paths can also be crucial. These needs are similar to those of elderly non-transgendered persons who find that social network support and community resources are important for the ongoing maintenance of well-being. Data for the elderly transsexuals and transgenders are unavailable at present.

Elderly persons frequently develop a high degree of spirituality, though not necessarily a great desire to attend traditional church or other religious services. Although the patterns of participation in religious activities among gender minority persons are not currently known, recent survey research has revealed that a majority do self-identify as being a part of a traditional religion or as being highly spiritual (Witten & Eyler, unpublished data).

Gender transition at any age requires physical, legal, and social adaptation. Although advice available within the gender community to persons beginning this process often emphasizes the physical aspects (e.g., how and where to obtain appropriate hormonal and surgical therapies), the other components of the process predominate in many cases. Important steps include legal name change and revision of pertinent documents (including driver's license, passport, insurances and governmental records, employment and educational records, and financial documents). In many states, the birth certificate sex can also be legally changed following genital reconstruction surgery (including sex reassignment surgery). Furthermore, the prevailing belief that changing one partner's sex will invalidate a legal marriage is not accurate; existing marriages can not be forcibly dissolved by the government of the United States.

Family relationships may be altered following the older person's "coming out" with regard to his or her gender identity. Fatherhood and motherhood, siblingships, grandparenthood and other aspects of the family constellation may be reevaluated during the gender transition process. Children and young adults are usually (though not always) accepting of gender change. Young children may respond well to being offered an actual or fictitious reference to provide even a tangential

"model" for transgenderism (such as Dustin Hoffman in the film, "Tootsie," or Robin Williams as "Mrs. Doubtfire.") Children ages four to seven often still practice magical thinking to a higher degree than their older peers, and frequently have the least difficulty in accepting cross-dressing, transgendered and gender transitioning adult relatives (personal communication, Randi Ettner, August 20, 1999). Therefore, concerns regarding the appropriateness of disclosing gender minority behaviors to grandchildren and other young relatives are unwarranted. However, young children are also vulnerable to the prejudicial attitudes of their parents, and may react negatively if their parents are rejecting of a grandparent or older relative.

Although gender transition among the elderly, and within the context of a very long term marriage or partnership, is still relatively rare, experience with middle-aged couples in which one partner is transgendered or transsexual suggest several possible patterns. Many spouses or long term partners of transgenders or transsexuals will choose to maintain the relationship as their husband, wife or lover changes gender presentation, genital sex, or both. Many others will not. Couples who do maintain a marriage or partnership may need to "redefine" their relationship. (More versatile persons can maintain a sexual relationship; other couples become "friends", "sisters," etc.)

Body image. Gender transition later in life may enable the individual greater freedom of expression as her/his true self. Furthermore, the normal bodily changes of aging will be partially offset by hormonal and surgical therapies. Specifically, breasts that develop in mid-life or the elder years, due to cross-gender hormonal administration, will not begin the ptotic process until very late in life. Genital (labial or scrotal) ptosis will also be greatly postponed for individuals who have experienced genital reconstruction during the elder years. Conversely, the other normal changes of aging (e.g., body habitus, dermal integrity) will be experienced equally by transsexuals and their gender congruent peers, and the bodily changes associated with sex reassignment surgery, even if strongly desired, may represent a positive stressor for the elderly client. Geriatric care managers who are providing mental health services to older transsexual persons, are well-advised to prospectively address this potential with their clients, and to remain alert for more specific questions and

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complaints during (and especially after) the gender transition process.

Sexuality and intimacy. The greatest obstacle to sexual expression among older adults (particularly heterosexual women) is the lack of availability of suitable partners. Consequently, a MTF transsexual person who undertakes gender transition later in life is more likely to experience sexual isolation or deprivation than would have been the case prior to this transformation (i.e., when the individual had been perceived as male). In addition, the current cohort of elderly women has been primarily socialized to believe that female sexual behavior is acceptable only within the context of marriage, and possibly for the exclusive purpose of procreation as well. However, persons who change gender presentation later in life may share in these perceptions to a lesser degree than do their non-transsexual peers. Furthermore, sexual expression may be positively enhanced by the newfound congruence between the body and the psychological (true) self.

Information specific to sexual concerns of single, elderly cross-dressers is currently unavailable. Middle-aged and older MTF cross-dressers who are currently in heterosexual marriages have usually reached equilibrium during the course of the relationship, though this may have taken years to achieve. Women who are unaware of their husbands' cross-dressing behavior at the time of the marriage and who discover it at a later point may respond by leaving the marriage, by attempting to place limits on the context of the presentation *en femme* (e.g., only at home, or only at cross-dressing parties) or by embracing the cross-dressing as a sign of empathy with the feminine aspects of the psyche.

With regard to the mechanics of sexual functioning following sex reassignment surgery, few generalizations can be made. Orgasmic capability is preserved in the majority of FTM genital reconstructive procedures and in many MTF surgeries as well. However, the sexual response cycle usually requires a greater length of time among elderly persons than among their young and middle-aged peers. The effect of sex reassignment (and in effect, post-operative genital retraining) is not yet known. For elderly female-to-male transsexuals, genital reconstruction (including the placement of an implantable penile prosthesis) may result in a more reliable erectile capability than that which is commonly experienced by elderly genetic males. However, the

strength and integrity of the genital dermis may be reduced, relative to earlier in life, and may therefore compromise post-surgical recovery. Male-to-female transsexuals may also experience a lack of resilience of the neo-vaginal lining and labial skin. In addition, the vaginal vault is usually less distensible among transsexual women than their non-transsexual peers. The effects of aging on this phenomenon (as well as the initiation and duration of estrogen therapy and the timing of surgery) are not currently known.

Despite the aforementioned obstacles to sexual expression, most transsexual persons experience a positive development of personal sensuality when they are able to live in congruence with their deepest self-perception. Patterns of sensual expression are usually present across the life-span, with sexual behavior serving also as a vehicle for the basic human need of the sense of touch. When touch is absent, severe psychobiological stress and symptomatology can result. The increased sensuality experienced by transsexual and transgendered persons who are able to achieve a sense of bodily wholeness may serve to enhance physical and mental health by providing additional capability for healthy touch. Cross-dressing persons who are able to integrate temporary role change into healthy partnered or social relationships may similarly benefit.

Health care professionals can assist clients in this regard by validating the sensual expressions and potentials of their elderly clients, offering sexual counseling and education when needed, and assisting other family members in accepting the gender presentation and sexual expression of their older relatives. Increased education for health care professionals serving these communities, regarding gender diversity and sexual expression among the elderly, may also be needed in order for professionals in inpatient, chronic, and acute care settings to provide appropriate and compassionate care for their older clients and patients. Dispelling myths regarding elder sexuality, providing information regarding the usual physical changes of aging and the human sexual response cycle across the lifespan, and offering interventions which address sexual expression in cases of physical disability, may also be particularly useful for social workers and other professionals who provide care to older persons.

Assisted living and social

support. The needs of older members of the gender community are similar to those of their non-transgendered peers with respect to the significant life transitions of the elder years. Loss of the spouse or significant other (and longstanding friendship group) due to death, decreased ability to maintain a private residence, loss of driving capability, transition from an independent residence to an assisted living environment (and ultimately to dependent nursing care) serve to erode personal control and are significant issues in the lives of all persons who survive to become the "oldest old."

In the case of transsexual, transgendered and cross-dressing elders, these challenges are compounded by issues regarding disclosure, privacy, isolation from transgendered peers (due to a more specialized [minority] community social system which is further decimated by aging and death of its members), specialized health care needs, and the potential for ostracization and judgment by the health care professions and other care providers. Within the gender community, transsexuals who have undertaken sex reassignment surgery at earlier life stages may not experience these difficulties, due to congruence between gender presentation combined with elimination of historical ties to the pre-transition life which occur with the passage of time. However, transgenders, cross-dressers, and transsexuals who undertake transition during the elder years must make numerous decisions with regard to sharing confidential (and potentially sensational or ostracizing) personal information with their caregivers. In addition, post-operative transsexuals must confide with their physicians and other health care professionals with regard to past medical history, or risk later exposure. For example, an MTF woman who has completed sex reassignment surgery in her youth will still retain her prostate. Ideally, she should receive routine prostate examinations by a health care provider who is familiar with her past medical history. If this option is not available to the patient, her prostate may be perceived as a "rectal mass" during routine physical examination performed upon hospital admission.

Geriatric care managers can best assist older transsexual, transgendered and cross-dressing clients by providing them with information regarding the importance of routine healthcare (including preventive services), arranging referrals to providers who are em-

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pathic and supportive to members of the gender community, and educating others involved in the clients' care with respect to the realities of human gender diversity. This latter endeavor must include medical, nursing, and social work colleagues, as well as unskilled and semi-skilled assistants. In addition, facilitation of support group formation for older members of the gender community (Slusher, Mayer, & Dunkle, 1996); education of leaders of existing groups, such as those operated by religious organizations and gay/lesbian/bisexual networks; and specific inclusion of transgendered persons in visible roles within retirement communities, health center sponsored programs and other service networks, may positively impact quality of life within the gender community. Moreover, intergenerational dialogue should be established; the young transgendered must be made aware of the lifecourse issues of aging.

Conclusion and Closing Thoughts

Transsexuals, transgenders, cross-dressers, and other persons whose gender expression or identification is other than the "traditional" male or female represent a substantial but epidemiologically invisible minority group within the worldwide elderly population. Quality of life issues for this community have, as yet, been but marginally addressed within the medical and sociological literature (Docter, 1985). The intersex elder community remains invisible and there is no literature available on elder issues and intersex. The absence of detailed discussion within this article further magnifies the need for greater research in this area. Attention to the needs of the gender and the intersex communities with respect to biologi-

cal, medical, psychological, and socio-cultural facets can be best served through a comprehensive and holistic approach, including family, provider, and community education and the development of appropriate professional and community networks. Health and social policy development on behalf of both the transgendered and the intersex elderly (including the assurance of nondiscrimination with regard to quality healthcare services, privacy, confidentiality, respectful treatment and caregiving, and personal safety) is also strongly needed (Witten, 2002).

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